Role of Authors

Conducting a scoping review with multiple researchers/authors is an iterative process which involved each of us in sometimes overlapping roles, and required ongoing dialogue at each stage of the research and writing process.

**RICHARD INGRAM**: Primary scoping search; initial coding, rating and analysis of articles; participated in writing drafts of the report.

**ADRIENNE WASIK**: Reviewed searches; extended the analysis of the articles; participated in writing drafts of the report; edited final report.

**RENEE CORMIER**: Conducted supplementary searches; initial coding, rating and analysis of articles; participated in writing drafts of the report.

**MARINA MORROW**: Reviewed searches; reviewed and refined analysis of the articles; participated in writing drafts of the report; edited final report.
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Executive Summary

Health inequities have been singled out by researchers, policy makers, providers and activists as a site for imperative ethical action. Inequities are socially produced and structurally driven, and therefore can be ameliorated or even undone. Although the context and specific social and structural determinants for health can overlap with mental health, inequities in mental health also operate distinctly and are overlaid with the additional stigma and discrimination that often accompanies a mental illness diagnosis. Those committed to improving mental health outcomes must consider their role in combating the specific inequitable conditions that affect mental health.

One manner to address this is through improved analytic tools, clearer conceptualizations, and methodological development. With this in mind we undertook a scoping review of the literature to examine how social inequities are currently being conceptualized and operationalized, and to examine the various theoretical frameworks within which inequity is understood. This report details the process and findings of the scoping review. We based our methodology on Arksey and O’Malley's five stage process. We took the additional step of measuring the relative contribution of journal articles to our specific research questions:

1. How are social inequities currently being defined and/or conceptualized within and beyond the fields of mental health and substance use?

2. What theoretical frameworks and/or paradigms are currently being used to study social inequities within and beyond the fields of mental health and substance use?

After applying our exclusion and ranking criteria a total of 59 articles were included in the review. Regarding our first research question we identified five main clusters of inequity terminology: ‘social inequities,’ ‘social inequalities,’ ‘social disparities,’ ‘structural barriers’ and ‘oppression and discrimination.’ This demonstrates the many different terms that are used to describe how unequal social relations and structures of power operate to produce experiences of inequity and inequitable outcomes, treatment and access to care. The results show that despite a frequent lack of definitional clarity, many of the authors we reviewed were working with social and structural definitions of inequities, that is, the ways in which social systems, systemic inequities and entrenched practices of discrimination affect mental health. We conclude that the definitions that best capture the links between mental health and social inequities are those that emphasize the structural nature of inequities and thus place a clear focus on societal power arrangements. For this, intersectional frameworks are best, as they elaborate on the complexity of intersecting social categories, like class, gender, ethnicity, disability and geography and locate inequities in systems of power.
In addressing our second research question, we identified four overlapping theoretical frameworks for the study of social inequities: (1) Determinants of health, (2) Social justice, (3) Sociological (structural analysis, critical social theory, social context) and, (4) Feminist (intersectional and postcolonial). Key themes that emerged within and among the frameworks included: attention to social justice, reflexivity, intersections among social location/context/systems/structures, and the epistemological significance of lived experience.

In the context of mental health policy and practice, biomedical and positivist research paradigms have dominated the field. We suggest that these frameworks are inadequate for surfacing inequities and their role in mental health, and we proffer that the application of intersectional knowledge to policy and practice is critical for addressing social inequities in mental health.

With this in mind we conclude with a discussion of feminist intersectional approaches to research and argue that they are the most useful for understanding mental health in its intersections with social inequities. Further, we propose a set of guiding principles for the study of social inequities in their intersections with mental health: attention to lived experience; reflexivity; and social justice.
Introduction

The landmark report by the World Health Organization’s (WHO) Commission on Social Determinants of Health, Closing the Gap in a Generation: Health equity through action on the social determinants of health, opens with this assertion: “Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death” (CSDH, 2008, p. 3). The WHO goes on to state unequivocally that, “Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative” (CSDH, p. 26). Although primarily focused on inequities in physical health outcomes, the report also quotes Mathers and Loncar (2005), who predict that, “Mental health problems will become increasingly important. It is estimated that unipolar depressive disorders will be the leading cause of the burden of disease in high-income countries in 2030, and it will be number two and three in middle- and low-income countries, respectively” (quoted in CSDH, 2008, p. 30).

The WHO Commission and other researchers have singled out health inequities as a site for imperative ethical action precisely because these inequities are entirely avoidable and unfair; they are socially produced and structurally driven and therefore can be undone (Whitehead & Dahlgren, 2006). Experiences of health and illness always take place within social, cultural and historical contexts including environments of discrimination and oppression that will have distinct effects on different groups. Yet, experiences of health and mental health are not equivalent. Although the context and specific social and structural determinants for health can overlap, inequities in mental health operate distinctly (e.g., Hacking, 2002; Shorter, 2008). For example, there is a substantive literature on how diagnoses and labels of mental illness result in specific forms of stigma and discrimination, and a burgeoning literature that looks at how the very application of diagnoses and labels can constitute a form of inequity. This is referred to as ‘sanism’ (Perlin, 2000). The concept of sanism is used to understand the discrimination against people diagnosed with ‘mental illness’, but goes further in its aim to unsettle assumptions about rationality, normality and madness (Morrow & Weisser, 2012; Ingram, 2011). Wright, Wright, Perry & Foote-Ardah (2007) for example, argue that mental illness diagnoses lead to “structural forms of discrimination” (p. 81).

Those committed to improving mental health outcomes must therefore consider, as part of their overall praxis as health researchers and/or practitioners, their role in combating the specific inequitable conditions that affect mental health. Progress in this direction has
been impeded by several key challenges. First, the field of mental health and substance use continues to be dominated by biomedical conceptual frameworks, which works against social and structural understandings of mental health (Rossiter & Morrow, 2011; Morrow, 2013). Second, the meaning of key concepts related to social inequity is highly variable and not always carefully theoretically grounded within the health sciences literature (Graham, 2004; Kindig, 2007; Krieger, 2001; Whitehead, 2007). Finally, analytical frameworks that disrupt and politicize social inequities have yet to be fully operationalized in research, policy and practice (Rossiter & Morrow, 2011). As a result, we continue to lack knowledge about how mental health inequities persist and how best to ameliorate them.

As well, keeping mental health equity front and centre in research remains problematic. Social determinants models arising from population and public health have been criticized for inadequately interrogating the causes of social inequities. It is much more common for health researchers to merely describe the social gradient in health or the health outcomes of various unequally positioned social groups than for them to theorize or study the causes of social inequity (CSDH, 2008; Coburn, 2004; Labonte, Polanyi, Muhajarine, McIntosh, & Williams, 2005; Fenwick & Tausig, 2007; Raphael, 2009). It is even more rare for health researchers to politicize social inequities as a determinant of health and engage in critical advocacy or public policy action (Labonte et al., 2005; Raphael, 2009).

Improved analytic tools, clearer conceptualizations and methodological development are all required to address the challenge of mental health equity. One way to begin this process is to better understand how social inequities are currently being conceptualized and operationalized in the literature. With this in mind we undertook a scoping review of the literature to examine how the concept of “social inequity” has been defined and used, and to examine the various theoretical frameworks within which inequity is understood.

What we found is that researchers use a range of overlapping, but at times distinct terms to describe similar processes, depending on which mental health and health outcomes are being considered, and among which populations. The terminological differences are sometimes contingent on language traditions used in different geographic locales and on disciplinary differences, but also reflect the degree to which structural forms of oppression are acknowledged. Despite this lack of definitional clarity, it is apparent that many of the authors we reviewed are working with concepts that are in line with a moral imperative to diminish inequities.

Meanwhile, we found that researchers use a variety of frameworks and/or paradigms for studying social inequities in mental health and related literatures. Overall, social
determinants of health frameworks dominate the field, illustrating that frameworks that utilize social theories are emergent in mental health studies. Yet there was, overall, rising recognition of the importance of examining multiple, intersecting categories of privilege and oppression and of using theoretical frameworks that can better explain macro/structural factors.

Below, we outline our methods, followed by the detailed analysis of the studies we reviewed. We close by identifying gaps in the literature and by offering key principles/values that should inform future research on social inequities and mental health.

Methodology
Guiding and Specific Research Questions

This scoping review was undertaken under the auspices of the Centre for the Study of Gender, Social Inequities and Mental Health (CSGM). One mission of the CGSM is to generate knowledge about the complex interactions among social and structural factors and their contributions to inequities in mental health and substance use outcomes. Thus, this review represents a key resource informing the work of the CGSM. The terms of reference for the review emerged through a consultation with CGSM-affiliated investigators at a World Café on January 22, 2010.

Early testing of the scoping review’s database search terms revealed a paucity of literature on social inequities within the fields of mental health and substance use; therefore, the decision was made to expand the disciplinary scope of the review to include some literature related to health inequities more generally. As a result, this review includes articles that address health issues that are not always of direct relevance to mental health.

On the basis of this preliminary testing, as well as input and feedback from the World Café participants and consultation within the research team, we finalized a general guiding research question:

How have social inequities been conceptualized within and beyond the fields of mental health and substance use, and which of these are most useful for the study of social inequities in their intersection with mental health?

From this, we generated two specific research questions to guide the scoping review:

1. How are social inequities currently being defined and/or conceptualized within and beyond the fields of mental health and substance use?
2. What theoretical frameworks and/or paradigms are currently being used to study social inequities within and beyond the fields of mental health and substance use?

Methodological Framework

Various types of reviews are available to researchers, including knowledge syntheses, scoping reviews and systematic reviews, each with their own associated methodologies and goals. The framework for our literature review was developed based on Arksey and O’Malley’s (2005) methodology and was also informed by Johnston, Nimmo, Baughan & Kearney (2006); Anderson, Allen, Peckham & Goodwin (2008); and Davis, Drey, & Gould (2009). Arksey and O’Malley propose a five-stage process for undertaking scoping reviews: identifying the research question; identifying relevant studies; study selection; charting the data; and collating, summarizing and reporting the results—all of which we adopted for our purposes. In addition, following Johnston et al. (2006), we took the additional step of measuring the relevance and relative contribution of papers to the guiding and specific research questions.

Further, Anderson et al. (2008) differentiate among orientations of scoping reviews, including those intended for literature mapping, policy mapping, or conceptual mapping. Scoping reviews can also involve consultations with stakeholders and others with an interest in the results. We adopted a conceptual mapping orientation, and, rather than the stakeholder consultations utilized by Anderson et al. (2008), we used World Café methodology.

Finally, the work of Davis et al. (2009) informed our review. They contend that by “exploring the relationships and links between different elements of a concept within and across the evidence, theories can be developed that move the prescription and usefulness of the findings beyond a descriptive summary” (2009, p. 1398). Our review was thus intended to explore how social inequities are conceptualized within and across various disciplines and perspectives.

Scope of the Literature

We reviewed primarily peer-reviewed journal articles, as well as other publications (e.g., book chapters in edited volumes) that are directly relevant to the guiding research questions. The parameters of the review were set to surface the most recent literature in countries comparable to Canada. Thus, only documents dated from 2000 onward and originating from Canada,
the United States, the United Kingdom, Australia or New Zealand were included. Literature reviews published after 2000 but which focused on materials published prior to 2000 were also excluded.

Databases and Search Terms

Searches were conducted using dbWiz database wizard and EBSCOhost research database service through the Simon Fraser University library, Vancouver, BC. We sought advice from a reference librarian specializing in Health Sciences to assist with choice of databases and search terms. The team searched the following specific databases, commonly used within the health sciences and social sciences:

- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- MEDLINE with Full Text
- Global Health
- PsycINFO
- JSTOR – Sociology
- SocIndex
- Women’s Studies International

Searches were conducted in multiple stages, with each round becoming increasingly refined. This is consistent with Arksey and O’Malley’s (2005) procedures, which involve revising the search strategy and achieving a rigorous search retroactively. They describe the search strategy as “not linear but iterative, requiring researchers to engage with each stage in a reflexive way and, where necessary, repeat steps to ensure that the literature is covered in a comprehensive way” (p. 22). Thus, in the final round, the search terms were combined as follows:

- theor*
- + (and) gender OR sex* OR rac* OR indigenous OR aboriginal OR disab* OR class*
- + (and) equit* OR inequit* OR equalit* OR inequalit* OR disparit*
- + (and) mental health OR mental illness OR substance use OR addiction OR dependency OR harm reduction

In order to surface more articles, a secondary search was conducted using the above databases and Google Scholar. We used the following search terms for this secondary search:
Finally, a third search was undertaken, similar to the first search but replacing mental health and related search terms with simply ‘health.’ This search was conducted to try to surface some additional articles that discussed social and health inequities and related concepts as they pertained to social and structural factors. Due to the high volume of results, database search results were initially skimmed by title for potential relevance and utility, and later a much smaller subset were coded by the reviewers. In the end, eight additional articles were added to the review based on this more discretionary search (Graham, 2004; Kindig, 2007; Kirkham & Anderson, 2002; Larkin, Flicker, Koleszar-Green, Mintz, Dagnino, Mitchell, 2007; Mohammed, 2006; Morgen, 2006; Racine, 2003; Tarlier, Browne & Johnson, 2007).

Inclusion/Exclusion Criteria

After reviewing the articles and excluding some because they were published before 2000 or because they were duplicates or annotated bibliographies, 105 publications were left for analysis. The following information was then extracted from each item:

1. Type of article (i.e., research study, conceptual analysis, literature review);
2. Field of study (i.e., mental health/mental illness, substance use/harm reduction, health sciences);
3. Disciplinary orientation or interdisciplinarity;
4. Definition/description of “social inequities”;
5. Theoretical framework for studying and/or analyzing social inequities;
6. Social locations (e.g., gender, race) and structural factors (e.g., poverty, racialization) identified;
7. Definition/description of “social justice”;
8. Approach to “lived experience” (e.g., distant object of analysis or integral part of emancipatory research);
9. Implications for policy and/or practice.

Following the extraction of this information, two independent reviewers with different disciplinary backgrounds evaluated the remaining publications. Each reviewer read each
publication and assigned a number from 0 to 2 to reflect the significance and relative contributions of the item to the overall research questions (0 = little or no relevance and significance; 1 = somewhat significant and relevant; 2 = highly significant and relevant). When a publication discussed and/or contributed knowledge to at least point #4 above, it received a “2.” When a publication partially contributed knowledge to point #4, it received a “1.” If there was little or no discussion of point #4, it got a “0.” The intent of this process was not to achieve consensus, but to acknowledge and honour the experiences, expertise and biases of the two reviewers by only retaining publications that placed a central focus on the study and discussion of social inequities, however conceived, described or defined.

In the final review we included any publication rated as a “2” by at least one reviewer. Consensus on a ranking of “2” was achieved on 15 publications, while consensus on a ranking of “1” was achieved on 27 publications, and a consensus for “0” rankings took place for 8 publications, thus achieving an overall consensus on 48% of the publications. The majority of the remaining items (31 of the remaining 55 publications) saw a discrepancy in ranking involving one reviewer assigning a rank of “2” and the other a “1” or vice versa. Upon debriefing, the reviewers agreed that the discrepancies in ranking (particularly between a “1” or “2”) were largely due to opinions about whether there was an adequate definition or description of ‘social inequities.’ There were no cases where one reviewer assigned a “2” and the other a “0.” The total number of articles ranked as “2” by at least one reviewer and thus retained for further analysis was 59. Of these, 51 explicitly address mental health and/or substance use. The articles retained came from a range of disciplines, including social work, nursing, counselling, psychology, sociology, public health, anthropology, native studies and women’s studies.

Data Management, Charting and Analysis

The team managed the retrieved items using Central Desktop, an online collaboration tool, and by creating a data chart in Microsoft Excel that detailed the information extracted from the publication, including author(s), year of publication, title and points #1 through #9 identified above, as well as the reviewers’ rating of “0” to “2.” The chart became the foundation for data analysis. It was used to answer the research questions, identify overarching themes, discern gaps in the literature, and to identify key principles for studying and responding to social inequities in the field of mental health and substance use.
Limitations

Scoping review methodology has shortcomings that must be acknowledged in order to fully contextualize our findings. In particular, a scoping review is intended to provide a profile of the current state of knowledge in a specified field or area without in-depth assessment of each individual piece of evidence. Because of this, scoping methods are limited in their ability to fully explore conceptual and theoretical types of research questions of the type that we settled upon.

Decisions were made about search parameters, including which databases to search, which search terms would be used, and whether grey literature would be included or identified appropriately through these searches. As a result, the research was conducted using databases for health sciences, medicine, psychology, sociology and women’s studies. In retrospect, it may have been useful to include additional search terms such as “social structure,” and possibly even “structural violence” as keyword search terms, as well as to explore the feasibility of including single-authored monographs in addition to edited volumes, for it is often in those publications that authors have the opportunity to fully explore and develop key concepts. It may have been helpful to explore books in medical sociology and anthropology, as both disciplines have established expertise at the juncture of social theory, inequities and health. Moreover, law making, application of law, and interpretation of law are important aspects of mental health that were not included as part of this review.

Findings

1. How have social inequities been defined or conceptualized within and beyond the fields of mental health and substance use?

In this section we look at language use in the literature we reviewed, and how various authors include, define and describe social inequities and related key concepts. Attention to the language of social inequities is important because terms often reflect subtle differences in the understanding of the causes and outcomes of, as well as interventions for inequity, which, in turn, carry implications for the framing of research problems and methods. For example, the term ‘health disparities’ has been criticized for its neutral observation of differences in health outcomes without attributing those differences to unequal power relations or systemic disadvantage. Similar debates exist over the use of the terms ‘equality’ versus ‘equity’; in some circles, inequality is understood as being merely descriptive, much like the term ‘disparity,’ whereas ‘inequity’ is lauded for its moral assessment of inequality and its social causes.
Our scoping review identified five main clusters of social inequity terminology: ‘social inequities,’ ‘social inequalities,’ ‘social disparities,’ ‘structural barriers’ and ‘oppression and discrimination.’ Overall, the literature within the mental health field and across the wider health sciences presents inconsistencies, lack of consensus and often ambiguity or confusion in what is meant by social inequities and related key terms. Moreover, findings from the review indicate that the critique of the depoliticized meaning of ‘social inequalities’ and ‘social disparities’ may not be so straightforward.

Terminology, Definitions and Descriptions

Inequities Terminology

The term “social inequities” is used explicitly in 19 publications, 16 of which are articles related to mental health and/or substance use (Adelson, 2008; Aneshensel, 2009; Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, & Wong, 2009; Clark, 2003; Cobigo & Stuart, 2010; De Pauw & Glass, 2009; Guruge, Khanlou & Gastaldo, 2010; Hankivsky & Christoffersen, 2008; Kelly, 2009; Kindig, 2007; Kirkham & Anderson, 2002; Larkin et al., 2007; Li, Mattes, Stanley, McMurray, & Hertzman, 2009; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Tait, 2008; Tang & Browne, 2008; Tarlier, Browne, & Johnson, 2007; Van Den Tillaart et al., 2009; Williams & Sternthal, 2010). In three of these articles, authors expand this terminology to include “social, political, and economic inequities” (De Pauw & Glass, 2009, p. 12), “social and political inequities” (Van Den Tillaart et al., 2009, p. 156) and “social and historical inequities” (Tarlier et al., 2006, p. 128), as well as the variant “inequitable social conditions” (ibid, 127). While a few articles included in this scoping review define ‘health inequity,’ surprisingly, none of the 19 publications that explicitly use ‘social inequities’ terminology actually define it.

In fact, all 19 of these publications use social inequities either interchangeably with other concepts, such as social inequalities or social disparities, or leave it vaguely characterized, with the reader left to infer the meaning from the surrounding text. Only Aneshensel (2009), a mental health sociologist, comes close, in a passing reference, to defining social inequities as an “unjust and avoidable” cause of health disparities (p. 378). Overall, authors use a range of language to describe the term, and they stress different elements depending on each article’s focus. These elements include social location, the social environment, risk factors, socioeconomic factors, poverty, oppression, inequitable social structures and/or conditions, marginalized historical and social contexts, racism, colonialism, social exclusion, discrimination, and asymmetrical or unequal power
relations. For example, in an interdisciplinary study exploring understandings of HIV/AIDS among Aboriginal youths in Toronto (Larkin et al., 2007), social inequities terminology is used in the following context:

HIV infection patterns follow the biases of social inequity, with youth from marginalized groups most at risk. Aboriginal peoples are disproportionately affected by social, economic and behavioural risk factors (such as poverty, substance abuse, sexually transmitted diseases, limited access to health care services) that can increase vulnerability to HIV infection. (p. 179)

Here, “social inequity” is thus broadly characterized (i.e., as “social, economic and behavioural risk factors”), and the elements linked to it reflect the circumstances specific to the population under study (i.e., “poverty, substance abuse, sexually transmitted diseases, limited access to health care services”). Others, like De Pauw and Glass (2009), take a more detailed approach, citing an even a greater number of linked elements as directly relevant to the field of mental health:

Gender intersects with other socio-economic factors influencing mental health, such as ethno-racial background, Aboriginal status, poverty, (dis)ability, newcomer status, and sexual orientation. Aboriginal youth, for example, face many social, political, and economic inequities related to a history of cultural oppression, including poverty, racism, inter-generational effects of residential schools, and lack of access to health, social, and educational programs. (p. 12)

Tait (2008), meanwhile, uses “social inequities” to mean factors that contribute to negative health outcomes:

Western medical models of diagnosis and treatment marginalize the historical and social context of their suffering, the social inequities that exacerbate their distress, and the inner strengths and resilience of Aboriginal peoples and their cultures to survive despite ongoing adversity. (pp. 29-30)

Tait also provides descriptions that, arguably, further characterize social inequities, such as, “the broader health and social determinants that affect the lives of these women” (p. 31) and “unique cultural identities, histories, and sociopolitical contexts of Aboriginal peoples” (p. 40).

Adelson (2008), a medical anthropologist writing on the discourses of stress and social inequities of First Nations women in Canada, does not define social inequities either, but instead, historicizes inequities by linking them to the following elements: “particular local, cultural, and historic conditions” (p. 317) and “social and economic conditions” (p. 326); to “complex cultural contexts” (p. 326), “larger socio-political process(es)” (p. 329) and the
“present-day remains” (p. 329) of “post-colonialism and neo-colonialism” (pp. 317 and 329); to “intergenerational and gender relations” (p. 326); to “asymmetrical power relations” (p. 329) and “(asymmetrical) [sic] social relations” (p. 316) and, finally, to the institution of the Anglican church (pp. 325-326).

Writing on inequitable access to health care among Aboriginal people, Tang and Browne (2008) use multiple terms to signal social inequities, including “structural inequities” (p. 118), “inequitable access to health care,” and “unequal power relationships” (p. 123). Again, while “social inequities” is also employed, it is never defined. The reader is provided cues, however, as to its meaning, which relates, in this work, to unfairly unequal social locations that result in power differentials:

The ideological doctrine of ‘treating everyone the same’ can actually reproduce social inequities by blinding health care providers to their relative privilege and prejudices as well as the unequal power relationships between patients and health care providers, and how such inequality in power can intensify in the face of differences in ‘race’/class/gender. (p. 123)

These researchers specifically describe racism as one form of inequity (p. 124) and discuss “how ‘race’/class/gender relations organize differential experiences of health and health care” (p. 111). Thus, overall, Tang and Browne link ‘social inequities,’ with social locations and processes of domination, including racism, sexism and poverty.

Similar to this pairing of social inequities with other descriptive elements, we found other authors using ‘social inequities’ alongside a plethora of sister terms, but with little elaborate discussion of the nuanced meanings of individual terms. Instead, various terms are used interchangeably. For example, Kelly (2009) uses the following terms in her paper exploring how intersectionality and biomedicine can be integrated into the study of health disparities: “social inequities,” “societal inequities,” “social inequalities,” and “systemic inequalities.” In this case, the variant “societal inequities” is explicitly defined as “the result of the intersections of differences, for example, race, class, gender, sexuality, and other dimensions of inequality” (p. E43), while the other terms are used interchangeably. Li et al. (2009) also use a number of terms interchangeably, including “social inequity,” “social inequalities,” “social determinants of health” and “social disparities,” all of which they broadly describe as arising from “socioeconomic status, measured by such factors as level of education, income, and occupational status, greater access to resources and political power” (p. 3). Cobigo and Stuart (2010) apply terms
Interchangeably as well, including “social inequities,” “social barriers,” “social oppression,” and “environmental barriers.”

In describing social inequities, Kirkham and Anderson (2002) defer to the parallel term “power inequities,” which they define as “shifting identities and realities based on the intersectionality of other organizing features such as sexual orientation, class, gender, age, and so on” (p. 9). Going back to the earlier point about linked descriptive elements, in their writing, “inequities” also frequently appears in combination with the following elements: “a society structured by discrimination and inequities” (p. 2); “patterns of domination and inequities” (p. 5); and “inequities and injustices” (p. 8).

Other reviewed authors, while not using ‘social inequities’ terminology per se, do partake in inequities discourse. Racine (2003), for example, draws heavily from this discourse through the use of terms like “social discriminative practices” (p. 91), “asymmetrical power relations” (p. 96), “social discrepancies” (p. 99), “structural barriers” (pp. 91, 97), “socio-economic and racial inequities” (p. 99), “health inequities” (pp. 91, 96) and “healthcare inequities” (p. 95), all of which have political overtones, while also focusing on “the cultural, economic, political, religious, and social contexts within which health problems related to gender, race, and class inequities vary” (p. 97). Racine’s paper is exceptional in its close alignment with the ethical imperative attached to inequities discourse in the WHO’s (CSDH, 2008) report on social determinants of health, discussed at the opening of this review. In the rest of the reviewed articles, that alignment is weaker. For example, Beckett, Nyrop, Pfingst and Bowen (2005) connect to inequities discourse when they use “socio-economic inequities” to refer to the disparate life circumstances of Black and Latino people compared to white people. In these instances, the term carries the ethical weight of a need to rectify this disparity. However, this meaning of the term disparity is used inconsistently in the rest of the paper, where it is most often used just to point out differences between populations.

We identified four articles that provide clear definitions of ‘health inequity’ (three of which explicitly address mental health and/or substance use) and that, together, provide a potential template for defining social inequities: Coursen, 2009; Kindig, 2007; Marmot et al., 2008; and Pauly, 2008. Pauly (2008) is particularly useful in this regard, succinctly defining ‘inequities’ in such a way that could be extended to ‘social inequities’; “In this commentary, the term ‘inequities’ is used to refer to differences that are unfair or unjust as a result of structural arrangements that are potentially remedial” (2008, p. 5).

Inequities, as opposed to inequalities, are avoidable, harmful, socially constructed differences, which therefore make them unfair and unjust.
Marmot et al. (2008) add to this by explicitly stating that both health and social inequities are influenced by one’s social location, as well as by larger systems and hierarchies of power. They define ‘health inequities’ as “systematic differences in health for different groups of people” that are “avoidable by reasonable action.” As such, “their existence is, quite simply, unfair” (p. 1661). Marmot et al. (2008) also define “gender inequities” as “Biases in power, resources, entitlements, norms and values, the way in which organisations are structured and programmes are run which result in lower social positions and poorer health for women and girls” (p. 1666).

These authors then pin the causes of health inequities, both within and between countries, on “the structural determinants and conditions of daily life,” such as “the unequal distribution of power, income, goods, and services,” as well as on “poor social policies and programmes, unfair economic arrangements and bad politics” (p. 1661). Finally, they link health to social inequities with an explicit discussion of social inequity as “also manifest across various intersecting social categories, such as class, education, gender, age, ethnicity, and geography” (p. 1667).

The strength of both the characterizations of health inequities by Marmot et al. (2008) and Pauly (2008) is that they include the causes of inequity in their definitions in addition to clarifying what makes inequity different from inequality. The causes of inequity, according to their definitions, include systemic differences, structural determinants, social processes, social and economic policies, unequal living conditions and distribution of critical resources for good health, and intersecting and hierarchical social positions. Inequities, as opposed to inequalities, are avoidable, harmful, socially constructed differences, which therefore make them unfair and unjust.

Inequalities Terminology

As the above researchers make clear, the relationship between the terms ‘inequality’ and ‘inequity’ is contested and their meanings highly variable. In Canada, inequality is most often understood to be a descriptive statement of difference, whereas inequity is a moral judgement about causes of these differences. Frohlich, Ross and Richmond (2006), Canadian authors not included in this scoping review, epitomize this position, writing in defence of their choice to use inequities rather than inequalities terminology, that: “Inequality refers to the state of being unequal, and inequity refers to fairness or the application of general principles of justice to current or supplement the law. We give preference to the term equities as it underscores the inherent ‘unfairness’” (p. 133, fn 2). However, as Pauly (2008) notes:

Internationally, the terms inequality and inequity are often used in multiple and conflicting ways. In the U.K., for example, inequalities are
often understood to be the same as inequities. From a population health perspective in Canada, inequality refers to differences between groups that may or may not be of concern. (p.4)

The publications included in this scoping review that use ‘social inequalities’ terminology reflect this variable meaning, whether for disciplinary or geographic reasons, or for more idiosyncratic ones. In some instances in the literature the term ‘social inequalities’ merely refers to a neutrally observed state of difference or variance about health or mental health. More commonly, however, a clear structural critique is evident in its use.

Overall, we found that, compared to ‘social inequities,’ ‘social inequalities’ was somewhat less likely to be used in the articles we reviewed, and more likely to be explicitly defined. The terminology appears in 14 of the articles we analyzed (10 of which discuss mental health and/or substance use) (Alegria, Perez & Williams, 2003; Berman et al., 2009; Burman & Chantler, 2003; Collins, von Unger & Armbrister, 2008; Coursen, 2009; Campbell, Cornish & McLean, 2004; Candy, Cattell, Clark & Stansfeld, 2007; Graham, 2004; Kelly, 2009; Lewis, 2007; Li et al., 2009; Morgen, 2006; Racine, 2003; Williams & Sternthal, 2010). Some like Kelly (2009), Li et al. (2009), and Williams & Sternthal (2010) use “social inequalities” interchangeably with other terms. In two other cases the term stands in for, and is eventually replaced by others more specific to the content of the paper—“gender inequality” in Lewis (2007) and “income inequality” in Coursen (2009). Racine (2003) defines social inequalities as being “located and constructed within a political, historical, cultural, and economic context” (p. 94). Alegria et al. (2003) describe social inequality as stemming from nonmedical or social determinants of health, such as housing, education or income support. Campbell et al. (2004) use Bourdieu’s concept of capital to describe how social inequalities are perpetuated through micro-social mechanisms based on economic, social, cultural and symbolic capital.

Candy et al. (2007) explicitly understand social inequalities to be “structured by the unequal distribution of a range of social influences” (p. 28). They provide concrete examples of sources of social inequalities (specific to their research interests), including parental separation and/or divorce in childhood; unemployment; work-related psychosocial issues; poor interpersonal relationships; and cumulative deprivation (measured by multiple indicators, such as income and housing quality and poor quality social support and social relations) (p. 29).

In touting the applicability of intersectionality theory to the study of social inequities in mental health, Berman et al. (2009) use “inequalities” terminology differently, providing a
comprehensive description of the importance and impact of macro-level factors on the lived experiences and health of individuals and groups: “An intersectional analysis directs attention away from an exclusive focus on individual stories and experiences, to consideration of larger systemic and structural inequalities” (p. 421). In this instance ‘inequalities’ terminology is used to reflect the discipline or theoretical perspective of the author(s) or the population of interest in the article. As a result, ‘inequalities’ terminology is often paired with language reflecting discussions of gender, race and class. Burman and Chantler (2003), for example, identify their focus of interest as “race inequalities,” “class inequalities” and “gender inequalities.” Likewise, Collins et al. (2008), in their study exploring the multiple layers of vulnerability in a population of Latino women with severe mental illness, explicitly identify their interest in examining “power inequalities in the intersection of gender, race/ethnicity and class” (p. 396).

Morgen (2006) similarly uses “structural/systemic inequalities” (pp. 408, 415) to describe the bias, stereotyping and discriminatory behaviour that ultimately contribute to inequitable access to health care for oppressed groups in the United States, arguing that categories like race, ethnicity and sexuality are “mutually constitutive” and intersecting (p. 398).

Disparities Terminology

While “disparities” or “disparity” was used as a search term in this scoping review, the number of publications using “disparities” terminology was not tracked. However, as we have already seen there are examples in the literature of where “inequities,” “inequalities,” and “disparities” terminology has been used interchangeably (e.g., Kelly 2009, Li et al. 2009). Like the term ‘social inequalities,’ the term ‘health disparities’ has been criticized for its neutral portrayal of observed differences in social or health outcomes, without attribution of those differences to unequal power relations (Kindig, 2007; Kelly, 2009). As Kindig writes:

An important issue here is whether the most commonly used term, disparity, means just inequality or difference or whether it incorporates the ethical connotation of being unjust or unfair. (p. 147)

Yet, the review found evidence that while the term ‘disparities’ is still used in its most conventional sense—as mere measurable differences—it is also applied alongside references to social inequities, social inequalities and structural forces.

Primm, Vasquez, Mays, Sammons-Posey, McKnight-Eily, Presley-Cantrell, McGuire, et al. (2010) are examples of scholars who adopt a more positivist reading of “disparities”: “Health disparities are defined as ‘differences in the overall rate of disease incidence, prevalence, morbidity, or survival” say Primm et al. (2010, p. 1), adding that “We describe mental health
disparities among racial/ethnic minority populations, such as differences in prevalence rates, diagnoses, access to care, and sources of care” (ibid).

But others, including Kelly (2009), in her work on intersectionality, use the term differently, defining “health disparities” as the “gaps in the quality of health and healthcare across racial, ethnic, and socioeconomic groups” (p. E42). This researcher openly acknowledges concern with the term: “Some intersectionality scholars use health inequalities rather than health disparities arguing that disparities suggests the need for measurement rather than action, has only a mild connotation, and that it minimizes the urgency and costs of social injustice” (p. E42). Kelly links this to the need for social justice by categorizing ‘health disparities’ as among the many “inequalities in power and social inequities” that must be examined and challenged through social action (p. E44).

Somewhat similarly, Safran, Mays, Huang, McCuan, Phuong, Fisher, McDuffie, et al. (2009) use “mental health disparities” to refer to measurable health outcomes while incorporating a critical understanding of the term by explicitly referring to the impact of system- and structural-level determinants and the complexity of the relationship between the two: “Mental health disparities are complex, challenging problems that involve multiple determinants at the individual, community, program, system, and policy levels” (p. 1964).

Barriers Terminology

Eighteen articles (16 of which pertain to mental health and/or substance use) use “barriers” terminology to describe factors contributing to health disparities and/or health inequities (Barn, 2008; Berman et al., 2009; Benbow, 2009; Browne et al., 2009; Bryant-Davis, Chung, Tillman, & Belcourt, 2009; Coursen, 2009; Cobigo & Stuart, 2010; Guruge et al., 2010; Hankivsky & Christoffersen, 2008; Kelly, 2009; Lynam, 2005; Pauly, 2008; Philips and Philips, 2006; Primm et al., 2010; Racine, 2003; Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008; Tang & Browne, 2008; Tarlier et al., 2007). However, authors’ use of this term and the relationship they see between barriers and health outcomes vary significantly. In the majority of cases (n = 12), barriers refer to difficulties accessing health care, use, quality, and/or appropriateness of health care and services. For example, Phillips and Phillips (2006) refer to barriers to health care for women with disabilities as “physical barriers, financial barriers, a lack of training and knowledge among healthcare professionals, and what may be called ‘attitudinal’ barriers” (p. 135), Similarly, Primm et al. (2010) name specific barriers to accessing mental health care for racial/ethnic minorities in
the United States, “limited English proficiency and health literacy pose barriers for immigrant populations” and “[lack of] medical insurance coverage” (p. 2). And, in a related fashion, Coursen (2009) uses the terminology of “policy barriers” affecting “vulnerable groups,” and names “fluctuating eligibility and renewal requirements, cost-sharing strategies, and levels of provider reimbursement” as concrete examples (p. 10).

In many cases, barriers are discussed as relevant to, and are specifically identified with the population under study. Barn (2008), for example, identifies barriers to mental health and social care specific to Bangladeshi women, while Bryant-Davis et al. (2009) describe the complex relationship between multiple barriers to care and mental health outcomes among Indigenous women who have been victims of sexual assault, and Pauly (2008) closely examines the relationship among barriers, access to health care services, and health outcomes among street-involved populations.

Like Pauly, who treats access to health care as a determinant of health, two other articles go beyond describing a relationship between barriers and access/use of health care services to highlight the relationship between barriers and health status or outcomes. Tarlier et al. (2006), in a study exploring the role of nurses in remote First Nations communities in Canada, make the link between geography and poor health: “Geographic descriptors establish … the physical and logistical barriers that influence health in remote settings, such as distance, poor access, a small population base, and relatively few resources and amenities” (p. 128). And Kelly (2009) pinpoints the connection between macro-level barriers and health disparities among Latino women in the U.S.:

They often lack access to economic resources due to barriers to employment, unjust employment practices, lack of education and job skills, ineligibility for public financial support, and language barriers, all of which contribute to health disparities. (p. E49)

Some of these authors who focus on macro-economic barriers to accessing care use terminology such as, ‘systemic’ or ‘structural barriers.’ For example, Racine (2003), who adopts a postcolonial feminist perspective to critique nursing ideology, argues that these ideologies, as well as “the structural barriers that may constrain the utilization of public healthcare services by non-Western populations must be further examined” (p. 91). Tang and Browne (2008), meanwhile, in relation to Aboriginal populations in Canada, argue that: “Inequitable access to health for many Aboriginal people is further complicated by systemic barriers to accessing the health care they need” (p. 110).
While the above articles focus on barriers with regards to access, use, quality and appropriateness of care, several articles instead focus on barriers that create marginalization, an effect that relates, in turn, to health inequities. So, building on a health determinants framework to understand marginalization and its relationship to health, Hankivsky and Christoffersen (2008) cast structural and systemic barriers as “social forces that drive health determinants” (p. 275). They advocate for social action to combat these forces, including “challenging power or the inequities that go beyond material resources to relations of domination and subordination” (p. 275). Likewise, Berman et al. (2009) describe the role of barriers in further disadvantaging already marginalized girls (e.g., Aboriginal, new immigrant): “Barriers that arise from interlocking systems of oppression and other forms of social exclusion, including racism, classism, negative stereotyping, and legacies of colonialism, limit the ability of girls to (re)establish connections and, ultimately, generate dangerous spaces” (p. 242).

Oppression and Discrimination Terminology

In 8 articles (all of which discuss mental health and/or substance use), authors use “oppression,” “power,” and/or “discrimination” terminology to describe how macro-level contexts and factors contribute to the marginalization of disadvantaged populations (Goodman, Smyth, Borges, & Singer, 2009; Comas-Diaz, 2005; Lewis, 2007; Berman et al., 2009; Baskin, 2007; Collins, et al., 2008; Armour, Bradshaw, & Roseborough, 2009; Peng, 2009). In some cases “oppression” refers solely to one or more social locations. For example, Goodman et al. (2009) utilize what they call a “gender oppression” framework for their study linking interpersonal violence and mental health. But the breadth of the term is limited, as it only reflects the authors’ focus on the overall experience of women, while ignoring the diversity of women’s experiences as structured through social relations of gender, race, ability, etc. They apply a second term, a “social oppression” framework (p. 321), to narrowly extend their analysis to include the experiences of low-income women.

Others explicitly link ‘oppression’ terminology to the term “power.” Lewis (2007) argues that gender oppression must be tackled through a power analysis: “I have suggested adopting a wide analytical lens focusing on power through which gender as well as other intersecting forms of oppression can be studied” (p. 289). Using a feminist bioethics framework, Dodds (2005) similarly discusses “gender oppression,” which she describes as gender and power biases/relations.

Meanwhile, Berman et al. (2009) make more explicit reference to thoroughgoing systems of oppression. They describe the impact of such systems as racism, classism and legacies...
of colonialism on the lived experience of marginalized groups of girls. Baskin (2007) also argues for locating the sources of oppression at the system level in attempts to change the mental health care system in order to improve mental health outcomes for Aboriginal people in Canada:

Western practitioners can join with Aboriginal peoples to address not only the specific vulnerabilities of those struggling with mental health challenges, but also the past and current sources of oppression — social, political and economic — which is where transformation is critical. (p. 3)

Finally, other researchers are concerned with the link between ‘oppression’ and ‘discrimination.’ For example, in their study exploring the lived experiences of African-American persons with severe mental illness, Armour et al. (2009) explicitly connect oppression and various forms of discrimination:

People’s experiences had overtones of oppression and non-specific discrimination. It was difficult to ascertain if reactions from others were due to having a mental illness, their race, being homeless, or being an ex-offender. (p. 612)

Peng (2009) makes a similar connection, although the discussion is specific to experiences of racial discrimination:

This article has presented perspectives that describe the ways in which ecological stressors such as racism and discrimination can impact the mental health of vulnerable minority populations, an interaction that can result in the expression of disability and the experience of multiple forms of oppression—minority and disability statuses—by these groups. (p. 96)

Terminology Summary

Overall, this review demonstrates the myriad of terms that are used to describe how unequal social relations and structures of power operate to produce experiences of inequity and inequitable outcomes, treatment and access to care. In the scoping review we found a lack of conceptual clarity with regards to the use of terms like “social inequities,” with several terms being used interchangeably. The differences in use of terminology were sometimes but not always contingent on the language traditions used in different geographic locales and disciplinary differences.
With regards to the contested terms ‘social inequality’ and ‘social disparities,’ which have been critiqued for sidestepping the ethical implications of ‘social inequities,’ (see Frohlich et al., 2006; Kelly et al., 2009; and Kindig, 2007), this review found room for debate. While, for some authors, these terms did equate to a mere state of difference, more often than not, the language of ‘social inequalities’ was used to signal an unacceptable state of systemic and socially structured difference, much like that of social inequities.

Lack of conceptual clarity exists, with many authors not fully defining the terms used. Still, some definitional commonalities did emerge. Overall, the studies concur that social inequities can be understood as causing, contributing to, resulting in or manifesting in health disparities (Clark, 2003), health inequities (Hankivsky & Christoffersen, 2008), or, more specifically, mental health problems and substance use (e.g., Beckett et al., 2005; Bryant-Davis et al., 2009). In addition, we found notable use of concepts such as structural barriers, often applied in relation to health care access, use and user experience, as well as other terminology specific to oppression and discrimination, the latter terminology being used to describe unequal power relations and the intersection of inequitable social structures and marginalized social locations. Therefore, despite a frequent lack of definitional clarity, many of the authors we reviewed were working with social/structural and ethical concepts.

Nonetheless, the variable use of terms related to social inequities represents a significant challenge for those involved in mental health research, policy and practice. As Bravemen and Bass-Haugen (2009) (not included in this review) assert, “The use of different definitions for health disparities, health inequities, and health inequalities presents specific problems in measurement, research, public policy, and programming” (p. 9). Currently, such terms can, on the one hand, describe similar or identical processes, while, on the other, be carefully selected by some authors to demarcate a nuanced difference from sister terms. Complicating matters, we also found that terms related to social inequity are sometimes left undefined and can become empty constructs when casually referenced and/or poorly integrated or unexplored within a text.

2. What theoretical frameworks and/or paradigms are currently being used to study social inequities within and beyond the fields of mental health and substance use?

In this section we look at the theoretical grounding for the works analyzed in this scoping review. Rather than operating discreetly, authors often combine two or more broad theoretical frameworks/paradigms in their study of social inequities. For example, many publications share in common attention to macro/structural forces and to intersecting inequalities and oppressions, as well as an impulse, if not explicit motivation, to eliminate or reduce unfair (i.e. unjust) health inequities. The frameworks used can be broadly categorized as:
1) determinants of health, 2) social justice, 3) sociological and 4) feminist. We found some similarities when comparing articles on health with those that address mental health and/or substance use, with the articles addressing mental health and/or substance use spread across the different frameworks.

Theoretical Frameworks/Paradigms

Determinants of Health

A social determinants of health perspective was the most ubiquitous within this scoping review. This perspective, which foregrounds the effects on health of social factors such as age, gender, culture, Aboriginality, etc., emerges primarily from the field of population and public health. To understand the current thinking about social determinants it is worth noting that some current research sees two goals within ‘population health’ (Graham, 2004). One is to improve the health of the population as a whole. The second is to reduce health inequities among differing populations. For this reason, Graham (2004) argues that we ought to distinguish between social determinants of health and social determinants of health inequities. Graham criticizes social determinants frameworks for being overly deterministic and for inadequately theorizing and responding to structural factors (Graham, 2004). Thus, in analyzing the heavy presence of the social determinants perspective in the literature, it is important to point out that this presence is not synonymous with a social or health equity perspective.

However, this review shows that the use of this framework in the literature is consistent with aspects of equity frameworks. In fact, within the field of population health, the review showed that health determinants terminology is shifting away from neutral terminology such as “determinants of health,” to phrasing such as “social determinants of health inequalities” (Graham, 2004), “social determinants of equity” (Primm et al., 2010), and “determinants of health equity” (Marmot et al., 2008). The challenge for those working from an equity perspective within population health research and policy is that determinants of health are still quite often conceptually limited to risk factors that are understood to have a causal relationship to poor health outcomes (e.g., Kindig, 2007), and it is often quite difficult to ‘prove’ social or structural determinants in the causal sense. Graham (2004) provides a succinct argument for the shift in thinking about the relationship between determinants and health outcomes:

The concept of social determinants is central to [public health] policies, with tackling the social influences on health seen as a way to reduce health inequalities. But the social factors promoting and undermining the
health of individuals and populations should not be confused with the social processes underlying their unequal distribution. This distinction is important because, despite better health and improvement in health determinants, social disparities persist. (p. 101)

Primm et al. (2010) also shift the focus to “social determinants of equity” as the primary locus in their model addressing racial and ethnic disparities in mental health. They propose that poverty, housing status, education, access to resources and institutionalization interact with health care systems to affect mental health outcomes. With a similar aim of keeping equity at the fore, Marmot et al. (2008) conceptualize determinants of health within a macro-system perspective by adopting terminology that includes “structural determinants” and “determinants of health equity.” Importantly, they also explicitly promote recognition of the relationship between social determinants and health equity:

Routine monitoring systems for health equity and the social determinants of health are needed, locally, nationally, and internationally. Combined with investment, such systems will enable generation and sharing of new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness of measures to reduce health inequities through action on social determinants. (p. 1668)

Authors working within social determinants frameworks also stress the importance of attending to social context when seeking to diminish inequities in health outcomes. Primm et al. (2010) provide an example of this emphasis:

For nearly a decade, federal reports have called for a public health approach that addresses the social determinants of mental illness to eliminate disparities in diagnosis and treatment. A successful approach must consider racial/ethnic minorities in their social contexts because these social determinants influence health outcomes. (p. 5)

Meanwhile, in outlining the elements of the social determinants of health model, Graham (2004) also notes that various terms are used to refer to this social context:

Although the models differ in style and complexity, most represent health as the outcome of a web of social influences... The most distal factor is the social structure of society, variously labelled general socioeconomic, cultural, and environmental conditions, social structure, social context, and social, economic, and cultural characteristics of a society... Radiating
out from this societal level, the models contain a set of intermediate social factors: social position and its attendant working and living conditions, and the social networks of family and community. The intermediate social factors are ranged above a set of individual-level influences, including health-related behaviors and physiological factors. At the most proximal point in the models, genetic and biological processes are emphasized, mediating the health effects of social determinants. (p. 106)

Like the authors described above, others in this review refer explicitly to a social determinants of health framework, including Li et al. (2009) in their paper titled, “Social determinants of child health and well-being”; Candy et al. (2007), who use the phrase “social determinants of common mental disorders”; and Alegria et al. (2003), who refer to “nonmedical determinants of health.” However, more often than not, authors draw implicitly on a social determinants of health perspective in dealing explicitly with issues of gender, race or power inequalities; of social inequalities or disparities more generally; or of socioeconomic status, social position, social forces, social factors, social conditions, or even specific “factors” or “contexts” in health outcomes or experiences, like housing and income.

Social Justice

A) Social justice and human rights

Given the moral underpinnings of the concept of inequity, it is perhaps not surprising that moral arguments for health equity and the adoption of a social justice paradigm were quite common in the literature under review. The authors surveyed rarely define social justice or injustice, but rather, refer to the presence or amelioration of systemic disadvantage or difference, or to the unfair distribution of resources, power or health. In some cases, researchers argue for equity and social justice as goods in and of themselves, but more often than not, social justice is seen as a means to eliminate avoidable and unfair health inequalities. Marmot et al. (2008) make a direct link between health inequities and social justice within the social determinants of health framework: “Social injustice is killing people on a grand scale, and the reduction of health inequities, between and within countries, is an ethical imperative” (p. 1661). They call for social action that will change “the distribution of power within society” and that will therefore “challenge the unfair and graded distribution of social resources” (p. 1667).

The invocation of social justice is especially pronounced in the literatures adopting intersectionality and postcolonial approaches. In these studies, critical inquiry or critical reflection are seen as forms of social action and central aspects of social justice. Fighting
injustice through critical inquiry, challenging conditions that produce inequity, and taking a lead in new practices that foster equity are key themes of the social justice paradigm.

The relationship between intersectionality and social justice is strongest in Kelly (2009): “Feminist intersectionality research is driven at its core by the pursuit of social justice. Social action is used to examine and challenge inequalities in power and social inequities, among them health disparities” (E44). Hankivsky and Christoffersen (2008) also emphatically link intersectionality and social justice, along with determinants in health, arguing that social justice entails an explicit interrogation of power, critical social theory and social action, all in an effort to reduce health inequities.

Kirkham and Anderson (2002), meanwhile, employ postcolonial theory to approach social justice because, they argue, it provides a critical theoretical perspective “regarding the damaging effects of race in everyday life,” “the shifting and inconsistent operations of intersecting oppressions,” and “the everyday experiences of marginalization, as structured by the micropolitics of power and the macrodynamics of structural and historical nature” (p. 2). Describing their approach to studying nursing, they write that they will utilize:

- a postcolonial lens to envision how to meet nursing’s social mandate
- of addressing the social aspects of health and illness, situate individual
- experience within the larger social context, give voice to subjugated
- knowledges, and foster social justice through an uncovering of social
- inequities. (p. 9)

Indeed, they describe nursing as having both a “social and moral mandate,” which includes the “illumination of the experiences of those marginalized within society and within health care” (p. 2). They suggest that “nursing scholarship has begun to examine the role of the profession in fostering social justice” due to the realization that society is “structured by discrimination and inequities” (p. 2). Racine (2003) also writes from a postcolonial and social justice nursing perspective, stating that “Critical and feminist approaches represent promising avenues for eliciting new knowledge to address health inequities by shifting reflexive thoughts into transformative interventions aimed at achieving social justice—using research as a vehicle of social activism” (p. 92).
Browne et al. (2009), also studying nursing, are interested in a different tool in the pursuit of social justice: “cultural safety,” which they see as a potentially “important means by which equity and social justice might be operationalized” (p. 171). They propose that “what may be required to effectively use cultural safety in the knowledge-translation process is a ‘social justice curriculum for practice’ that would foster a philosophical stance of critical inquiry at both the individual and institutional levels” (p. 167). This “social justice curriculum” entails not only an “explicit focus on structural inequities,” but also, critical reflection on the part of nurses about “the social context of each patient” (p. 171), about “how we are all socially positioned within wider structures and discourses” (p. 169), and about “the wider culture of health care systems” (p. 176), in order “to ultimately help shape nurses’ practice in ways that could foster equity and social justice” (p. 169). In the case of Aboriginal inequities, Tait (2008) also sees cultural safety and social justice, along with self-determination, as the “building blocks for moving forward within the ethical space” of restoring the individual and collective health and wellness of Aboriginal peoples (p. 46).

B) Distributive justice

Within the social justice paradigm there is also a discursive stream debating different notions of justice, including distributive justice (i.e., more equal distribution of material goods) and equal versus equitable treatment (i.e., whether justice means treating everyone the same). For example, Phillips and Phillips (2006) write:

There is controversy in the United States and other countries about just what it means to allocate healthcare resources fairly, and it extends to the issue of distributive justice for persons with disabilities. Some believe that the differences possessed by persons with disabilities amount to disadvantages in society, including disadvantages in competing for education and employment, and that the government should expend funds to provide healthcare resources to persons with disabilities to attempt to compensate for these disadvantages. Others believe that this would merely stigmatize persons with disabilities rather than help them, and in any event what they need is not sympathy or compensation but freedom from discrimination. (p. 143)

In her paper on harm reduction among homeless drug users Pauly (2008) also considers the value of adhering to distributive justice precepts. Drawing on the work of Young (2001), Pauly writes:

Young, a feminist philosopher, argues that it is a mistake to reduce justice to distribution, claiming that the distributive paradigm ‘tends to ignore
the social structures and institutional context that often help determine distributive patterns. Young highlights the importance of addressing nondistributive issues such as decision making structures and processes, division of labor and culture and nonmaterial goods such as respect and power. Focusing on distribution of existing resource without attention to such issues does little to help us to understand how policies, social structures and resulting practices affect those affected by homelessness and drug use. (p. 7)

Pauly (2008) proposes that the distributive justice framework be replaced with a ‘social justice framework’ as a means of promoting systemic change for drug users, concluding that “conceptions of social justice that shift from distribution of existing material resources to a focus on social structures hold promise by surfacing the root causes of problematic substance use and homelessness…” (p. 8).

Approaching this question of unequal distribution of goods somewhat differently, Marmot et al. (2008) are concerned by:

The poor health of poor people … , the social gradient in health within countries, and the substantial health inequities between countries [which] are caused by the unequal distribution of power, income, goods, and services, globally and nationally. … This unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and cause much of the health inequity between and within countries. (p. 1661)

Graham (2004) shares this concern with the unequal distribution of social goods. As mentioned earlier, she distinguishes between social factors that influence health and the social processes that determine their unequal distribution, and argues that most policy applications of determinants of health frameworks blur this distinction, leading to the false assumption that tackling the social determinants of health will reduce health inequalities/inequities. Graham argues that social determinants models that focus on aggregate gains over the distribution of inequalities will not get at the social gradient in health. Clearly, the meaning and merit of distributive justice is context-dependent.
Coursen (2009) also seeks to maintain clear distinctions, here, in the name of socially just health outcomes, particularly between what is equal and what is equitable within distributive justice. Noting that it is possible, in the distribution of health care goods, to have equal distribution that is still not equitable (for example, when priority of service is given to those with severe illnesses, even as the right to equal access to services is not addressed), Coursen (2009) contends that health deprivation based on inequity is a “concern of moral importance,” in other words, a social justice issue, that must be addressed through the assertion of rights to the “equal opportunity to obtain health care” (p. 8).

C) Participatory methods and reflexive practice

Some authors in this review see the amelioration of social inequities beginning at the local level. They argue for problematizing inequality within the research relationship or service delivery relationship through reflexive praxis and/or participatory methods. For example, calling for more self-awareness within nurse/patient interactions, Tang and Browne (2008) write:

> We therefore challenge health care providers (and those involved in their professional education) to critically examine their own positionality and how, even if not consciously knowable to them, they are ‘embedded with power’ (England 2004, p. 300) to exercise ‘social control’ by controlling the distribution of resources to people in vulnerable positions. (pg. 124)

Mohammed (2006) also highlights the need for critical reflection in nursing practice, calling for “equal partnership” between nurses and adolescent patients, and arguing that critical social theory should be used “to examine how power relations in healthcare interactions affect interactions” between nurses and patients (p. 70). Mohammed concedes, however, that this goal is difficult to achieve, particularly due to two factors: first, the “uneven distribution of health-related knowledge” that positions nurses as the authority (Allen, 1987, quoted in Mohammed, 2006), and the “prevailing stereotype of adolescents as irresponsible, noncompliant, or unable to make ‘good’ decisions (Stevens, 2004, quoted in Mohammed, 2006, p. 70). The only way past these hurdles, Mohammed argues, is to trouble both factors in the name of partnership.

In the same vein, Van Den Tillaart et al. (2009) advocate for reflexive, critical, as well as transformative nursing practices:

> It is critical that health-care providers listen to and explore with mental health clients the clients’ experiences of the health-care system. If nurses and other health-care professionals are to act with an emancipator intent that supports the empowerment of clients, then it is important
to acknowledge and lobby for system changes so that the women’s experiences of silencing, marginalization, and powerlessness are eliminated for all mental health clients. (p. 160)

Other authors see opportunities for greater social equity through participatory action research (PAR) and community-based research (CBR). In some cases, the goal is the inclusion of marginalized or disadvantaged community members (e.g., Shattell et al., 2008; Cockburn & Trentham, 2002), with the risk, as Campbell et al. (2004) point out, of further reifying inequities through selecting the most privileged within a group to take part. In other cases, the goal is to more critically alter power relations between the researcher and the researched (Kelly, 2009; Van Den Tillaart et al., 2009; Burman & Chantler, 2003), with sensitivity to inequalities within the research process, often achieved through sharing power.

**Sociological (structural analysis, critical social theory, social context)**

Individualistic and biomedical models of mental illness predominate in mental health research (Blehar, 2006; Fenwick & Tausig, 2007; Rossiter & Morrow, 2011). More often than not, mental health outcomes are viewed as individual attributes, and mental illnesses as brain disorders. The bias is towards decontextualized, apolitical and a-historical analyses of mental health. Sociological frameworks counter such tendencies by connecting social structures with individual outcomes. As Fenwick and Tausig (2007) (authors not included in the review) point out, mental health outcomes are not the “anomic or pathological result of person-environment misfit,” but rather “a routine result of social organization and inequality” (p. 143).

**A) “Fundamental” causes and macro-level influences**

Much of the literature in this scoping review tries to capture macro-level influences through various forms of sociological inquiry, whether via structural analysis, critical social theory or attentiveness to social context. Indeed, the sociological framework undergirds much of the critical inquiry called for in the social justice paradigm. For example, Li et al. (2009) champion the shift towards recognition of what they call “fundamental causes” of health inequity:

Instead of solely focusing on individual socioeconomic status (e.g. education, occupation and income), individual psychosocial attributes (e.g. social capital, social connectedness, perceived inequality) and neighbourhood characteristics, this new perspective looks into the macro forces that ultimately drive the social determinants of health and profound social injustice and health inequity. These include the nature of the dominant political economy and neo-liberalisms, the welfare state and globalisation and its consequences for health inequity. (pg. 5)
Taking up this perspective, Mohammed (2006), examining the impact of macro-level factors on health disparities from a nursing perspective, sees the defining role played by social structures like “economic organization, political systems, and societal power relationships that privilege some individuals while marginalizing others” (p. 68). Bryant-Davis (2009) also provide examples of structural factors that are relevant to social inequities facing racialized young people who experience sexual violence: “The simultaneous weapons of silencing and stereotyping within the education system, judicial system, economic system, social system, and media represent additional potential challenges that ethnic minority sexual assault survivors face on the road to recovery” (p. 331). Pauly (2008) describes the relationship of social inequities to structural factors, here, with homelessness and substance use as the issues of interest:

If homelessness and substance use are viewed through a neo-liberal lens, individuals are not only seen to be at fault but are failing to take personal responsibility for their homelessness and drug use. Such perspectives easily obscure the social and political structures that create conditions in which some individuals are more likely than others to experience poverty, homelessness, lack of education, lack of social support and so on. (p. 7)

B) Social context/social processes

As a means of situating their sociological understanding of social inequities, some publications in this review turn to the context, or multiple contexts in which populations exist. These authors’ identification of, emphasis on, and description of ‘social context’ (sometimes referred to as processes or forces) vary depending on their disciplinary and conceptual background; on which health issues they examine; and on the population under study. However, they share in common an attempt, using the discourse of social context, to signal, if not situate, important social processes at work in relation to health.

To reflect an emphasis on one or more aspects of the social context that may be more relevant to their particular research, authors employ a variety of terms, including “socio-cultural or cultural context" (Baskin, 2007; Bryant-Davis et al., 2009; Prussing, 2008), “socio-historical or historical context” (e.g., Adelson, 2008; Kirkham & Anderson, 2002; Tait, 2008; Tang & Browne, 2008; Utsey et al., 2010), and “socio-political or political context” (e.g., Benbow, 2009; Browne et al., 2009; Van Den Tillaart, et al., 2009; Tait, 2008; Tarlier et al., 2006).

Bryant-Davis et al. (2009) show how analyzing different social contexts can be put to use. For example, with regards to sexual assault within the African American community, taking
socio-historical context into account involves understanding stereotypes about African American female sexuality, and sexual and economic oppression in a patriarchal system. The authors contend that unique socio-cultural factors mean that sexual assault will be experienced and understood differently by different groups of women. They conclude that understanding the socio-political context of sexual assault can allow for a deeper comprehension of both the ways in which racialized women's bodies are eroticized and devalued, and the accompanying mental health effects on those women.

While this example usefully specifies the influence of particular contexts, other authors describe interactions between contexts. For example, using a feminist framework, Van Den Tillaart et al., (2009) demonstrate overlap between cultural and historical contexts in their study exploring the lived experiences of women with a mental health diagnosis:

Women whose behaviour is viewed in the absence of knowledge about historical events can bear the brunt of stigma. Without a cultural context or explanation to help others appreciate what occurred in historical events, such as the residual effects of colonization (Farmer 2004) and abuse (Tester 2007), ‘historical amnesia’ (Farmer 2004) then supports the perpetuation of society’s inaccurate stigmatizing and discriminatory opinions. (p. 155)

Likewise, Tang and Browne (2008) draw a link between historical and political contexts with regards to Aboriginal populations in Canada, and within the discourse of racialization:

While recognizing and respecting the cultural specificity and political relationships of Aboriginal people as embedded in a particular history of colonization, we take Aboriginality as a political category subject to be racialized, as well as a contested site imbued with political and colonizing discourses that shape how Aboriginality and Aboriginal people are sometimes ‘read’ by people from non-Aboriginal backgrounds and/or from the dominant culture. Moreover, we conceptualize Aboriginality as a lived experience that is invariably embedded in the history of colonization and in current political discourses, including racializing discourses that shape policy and everyday interactions. (p. 114)

Meanwhile, several articles prioritize elements of the social context, highlighting the particular importance of the historical context to marginalized populations’ experiences, and, especially, the long-lasting physical and mental health effects of colonialism and its contributions to mental health (e.g., Tait, 2008; Tang & Browne, 2008). In Adelson (2008), the
effects of the history of colonialism on Aboriginal people’s mental health in Canada are described as amplifying current, lived social inequities:

What I have come to understand from my discussions with the Whapmagoostui women is that although there are shared challenges in terms of the various historical, economic, political, and social determinants of stress in their daily lives, there is a concomitant perpetuation of the idea that “stress” needs to be managed on one’s own (e.g., as time away from daily routines). For these women, socially and culturally driven practices of inequity, heightened by the circumstances peculiar to the institutionalization of colonial and missionary practices, emerge as problematic predominantly through the individualized and embodied popular discourse of “stress”. (p. 328, italics added)

Thus, even with a particular emphasis on history, Adelson (2008) shares with the other authors reviewed in this section a commitment to critically examining the impact of social factors, forces and processes operating at the macro or structural level, and how these influence the social context of individuals and groups of individuals.

Feminist (intersectional and postcolonial)

A) Intersecting forms of oppression

Feminist intersectionality and postcolonial scholars analyzed as part of this scoping review share a common interest in social justice, critical inquiry, structural analysis and social context, with a particular focus on power relations, reflexivity, social change and multiple and intersecting social inequities. Both feminist postcolonial and intersectionality scholarship contrast with biomedical framings of health and mental illness by foregrounding the role of historical, political and social contexts in health inequities, and by revealing the extent to which the biomedical paradigm has been naturalized in health research and practice. Further, these overlapping feminist frameworks centre lived experience as critical to theorizing and practice.

According to Hankivsky and Christoffersen (2008), intersectionality is:

a theory of knowledge that strives to elucidate and interpret multiple and intersecting systems of oppression and privilege. It seeks to disrupt linear thinking that prioritizes any one category of social identity. Instead, it strives to understand what is created and experienced at the intersection of two or more axes of oppression (e.g. race/ethnicity, class, and gender) on the basis that it is precisely at the intersection that a completely new
status, that is more than simply the sum of its individual parts, is formed.
(p. 275)

Intersectionality as an analytic approach or a methodology brings to the forefront an understanding of power as it is mediated through a range of social relations that are based on things like gender, race, culture, ethnicity, sexuality, ability, class, etc. Thus, intersectionality’s analytic potential comes in its ability to understand complex relationships of power as they are experienced through a variety of interconnected oppressive systems and practices. As such, intersectionality has the potential to more cogently mine social inequities as they pertain to mental health and especially to factor in the specific forms of discrimination that people diagnosed with mental illnesses experience.

B) Decolonizing Research

Racine (2003) details what constitutes a feminist postcolonial praxis. In Racine’s case, this involves contrasting the experiences of those situated in dominant positions from “culturally different Others” on many levels, including their history, politics and gender (2003, pp. 96-7). As well, researchers must undertake “intensive reflexivity” in order to understand their own biases and to be able to “negotiate meanings with participants” (p.98).

Writing on health inequities, Kirkham and Anderson (2002) add a definition of “postcolonialism,” which, they say:

refers to theoretical and empirical work that centralizes the issues stemming from colonial relations and their aftermath (Cashmore, 1996). Its concern extends to the experiences of people descended from the inhabitants of those territories and their experiences within “first-world” colonial powers. (p. 3)

For Racine (2003), postcolonial feminism is a tool for distinguishing between cultural experiences by “decentering knowledge production, where the culturally different Other is heard and understood from standpoints located at the margins, and not from a centered position—also defined as the culturally dominant position” (pp. 96-7).

Likewise, Tarlier et al. (2006) see the postcolonial method as entailing an explicit critique of “othering,” particularly with regards to work with Aboriginal peoples:

Observational and interview data suggest that Othering is reflective of the difference that non-Aboriginal health-care providers perceived between their own worlds and the world of the local community. For example, one nurse who had relatively little experience working in remote First Nations
communities remarked, “I don’t think it matters how close you get or how much you’re involved in the social activities; we’re white, they’re Aboriginal.” As Browne (2005) points out, such framing of intercultural relationships in terms of “us”/“them” binaries (p. 79) reflects both “popularized assumptions” (p. 79) and racialized discourses that permeate social discourses in Canada and play a role in shaping many people’s constructions of Aboriginal people. (p. 141)

In describing how a postcolonial perspective informs the practice of critical health researchers who work with Aboriginal peoples, Tang and Browne (2008) note that it helps to ensure that power dynamics are made explicit and connected to social context:

we recognize an urgent need to bring to the open what might have been taken for granted, and question the unequal power relations that organize not only the experiences of injustice, but also the interpretation of those experiences by people coming from different historical and socio-political locations. (p. 124)

Tait (2008), who also writes about conducting research with Aboriginal peoples, advocates for trying to redress unequal power by using the research process itself to shift power. Tait subscribes to the OCAP principles of research with Aboriginal peoples: ownership, control, access and possession (see Schnarch, 2004). For Tait (2008), appropriate practices “assert a clearly defined and ethically sound approach to research that privileges the vested interests of Aboriginal peoples in ensuring accurate research concerning their communities”(p. 40).

C) Lived experience and reflexivity

Lived experience is identified in the postcolonial and intersectionality literature as a potential corrective to professional or expert knowledge production. Prussing (2008) writes that the incorporation of lived experience into research can challenge essentialism. Similarly, Racine (2003) endorses engaging health care practitioners in a reflexive process, to understand people’s lived experiences in order to deepen an understanding of the effects of power on encounters between clients and healthcare providers (p. 97).

However, only a few other authors in this review referred to “lived experiences” directly (e.g., Armour et al 2009, Prussing 2008 and Racine 2003). Barn (2008) calls it “lived reality (p. 71) and Adelson (2008) simply calls it “experience” (p. 317). More commonly, lived experience is implied, especially in the work of qualitative or ethnographic researchers, as in the case of Beckett et al. (2005), who conducted an ethnographic study and survey of drug users, and Lewis (2007), who studied experiences of gender and mental health (also see Adelson, 2008;
Larkin et al., 2007; and Shattell et al., 2008). These works often provide transcribed interview data as part of their findings, and direct, first-hand experience of research participants is simply referred to as ‘data.’

Authors sometimes use the term “voice” or “voices” to stand in for “lived experience” (e.g., Guruge et al., 2010; Lim and Browne, 2009; and Van Den Tillaart et al., 2009). Redwood et al. (2010) utilize the “photovoice,” method, which combines photography and narrative, to elucidate the connection for African Americans between the built environment and health, including mental health. Other signals to the inclusion of lived experience in the publications reviewed include key words like “narrative,” “interviews,” and “participation action research projects” (see Wright et al., 2007; Cockburn & Trentham, 2002; and Shattell et al., 2008). In two cases, the use of lived experience is autobiographical (Tenney, 2007, Comas-Diaz, 2005). Sometimes the lived experiences of mental health services user populations are researched indirectly, mediated through the reflections and experiences of service providers (e.g. Burman & Chantler, 2003 and Barn, 2008; also see Campbell et al., 2004).

More often than not, however, in this review, and in the context of social inequity research, study authors single out critical inquiry and reflexivity over reference to lived experience. Kirkham and Andersen (2002) are a good example:

Praxis begins with the researcher as he or she engages in reflexive critique of the research process itself (e.g., the relationships formed with participants, the influence of the researcher’s positionality, and the dynamics of power at work) and the nature of the knowledge being constructed. (p. 14)

Summary

In this review we have identified four overlapping theoretical frameworks for the study of social inequities: (1) Determinants of health, (2) Social justice, (3) Sociological (structural analysis, critical social theory, social context) and (4) Feminist (intersectional and postcolonial). To some extent authors’ choice of frameworks is discipline and population specific. For example, social determinants of health frameworks tend to be used more by scholars in population and public health, while sociologists tend to incorporate structural and feminist analyses. Meanwhile, researchers most often use postcolonial frameworks to understand issues emerging in First Nations Communities. Despite this, there was also substantial overlap in the use of some concepts across the frameworks. Key themes that emerged within and among the frameworks
included attention to social justice, reflexivity, intersections among social location/context/systems/structures, and the epistemological significance of lived experience. Some of the reviewed literature also turned the lens of equity onto the research process itself and focused on how research can change to be inclusionary and also to yield more understanding of the inequities being studied (Cockburn & Trentham, 2002).

Gaps in the literature

Based on this review, we have identified areas relevant to social inequities that are not adequately addressed in the literature. The first of these is inadequate attention to the concept of sanism. Although some of the articles discuss stigma and discrimination against people with mental illness diagnoses, few explicitly make the claim that sanism is a form of oppression and important to consider as a structural form of inequity. Thus, discussions about the ways in which mental illness diagnoses and treatment potentially reinforce oppressive norms of behaviour were absent in the review (Ingram, 2011; Fabris, 2011). In addition, there was surprisingly little analysis of the role of psychiatric and legal power in mental health. Authors were more likely to talk about inequity of access to services in mental health and/or to handle inequity as an outcome of mental health problems.

Another area of oversight is reflexivity in research. Although, some authors discuss reflexive practices, in the articles reflexivity as an important cornerstone of equity and social justice oriented research was more often neglected. Finally, lived experience as an important source of information about mental health was often ignored or not adequately explored in many of the articles.

Frameworks for studying social inequities and mental health

In this section we propose a definition for social inequities and mental health that takes into account the findings of this scoping review, and suggest key components and principles we think are most important for research into the interconnections between social inequities and mental health. We conclude with a discussion of some promising approaches for studying social inequities and mental health.
Definitions

The definitions that best capture the links between mental health and social inequities are those that emphasize the structural nature of inequities and thus place a clear focus on societal power arrangements. For this, intersectional frameworks are best, as they elaborate on the complexity of intersecting social categories, like class, gender, ethnicity, disability and geography and locate inequities within inequitable systems of power. To this end Hankivsky and Christoffersen’s (2008) definition of intersectionality is most useful:

— a theory of knowledge that strives to elucidate and interpret multiple and intersecting systems of oppression and privilege. It seeks to disrupt linear thinking that prioritizes any one category of social identity. Instead, it strives to understand what is created and experienced at the intersection of two or more axes of oppression (e.g. race/ethnicity, class, and gender) on the basis that it is precisely at the intersection that a completely new status, that is more than simply the sum of its individual parts, is formed. (p. 275, emphasis added)

With respect to how inequities operate in health, we turn to the definition offered by the WHO:

— Social inequity manifests across various intersecting social categories such as class, education, gender, age, ethnicity, disability, and geography. It signals not simply difference but hierarchy, and reflects deep inequities in the wealth, power, and prestige of different people and communities. People who are already disenfranchised are further disadvantaged with respect to their health — having the freedom to participate in economic, social, political, and cultural relationships has intrinsic value [...]. Inclusion, agency, and control are each important for social development, health, and well-being. (CSDH, “Closing the Gap,” 2008, p. 18)

From this, we can infer that marginalization by conditions of social inequity and negative health outcomes reinforce each other: hierarchies of wealth, power and prestige militate against achieving “the highest attainable standard of health” for all; and exclusion from decision-making directly and indirectly impacts on health and mental health. However, still missing from this definition is a clear articulation of how carrying a label of mental illness results in active discrimination against people, both at the individual and systemic levels, and how this is compounded by other experiences of oppression (e.g., sexism, racism, classism, etc.). Further, there is a need to recognize that diagnostic labelling takes place within a social context and
is thus influenced by societal prejudices and social arrangements of power. Sanism which attempts to understand the ways in which we understand ‘normalcy’ and ‘madness’ must become another key critical analytic lens for understanding mental health and mental illness (see Birnbaum, 2010; Perlin, 2000; Ingram, 2011; Fabris, 2011). With this in mind we suggest that mental health inequities be understood as caused by structural social arrangements (including sanism) which result in inequitable distribution of resources and active discrimination against individuals because of their membership in one or more disenfranchised group.

Key Principles

Definitions reflect, in part, conceptual frameworks. From the four overlapping theoretical frameworks identified, we can now derive a set of guiding principles for the study of social inequities in their intersections with mental health and substance use.

Reflexivity and Lived Experience

Reflexivity is necessary for understanding how power and privilege operate in mental health. Reflexivity is an epistemological stance that recognizes multiple subject positions and situated knowledges (Kippax & Kinder, 2002). Thus, for reflexivity to be useful it must move beyond acknowledgement of social location to the recognition of how those locations intersect with wider social, economic, cultural, political, historical and structural factors and to the recognition that the unique and multiple subject positions of individuals can offer valuable insight and knowledge. Connected to this, the lived experiences of psychiatric diagnoses and marginalization are important to the endeavour of research, practice and policy in two ways. First, lived experience is epistemologically significant in what it can reveal about disenfranchised subject positions, and how power and privilege operate within systems to produce differential outcomes. Second, the active participation of people with lived experience in research, policy and practice can transform knowledge-making practices and disrupt singular understandings of marginalization and mental distress. Within the context of research, certain research paradigms, including feminist, postcolonial and participatory action, lend themselves more readily to the adoption of reflexivity and the value of integrating lived experience into the research process.

Social Justice

Social justice, or the idea that inequities, however manifested, are unfair and unjust (and, therefore, changeable) is a moral imperative for all work in the area of mental health. Thus, as a principle for mental health research, social justice allows researchers to enact the commitment to ameliorating or eradicating systemic disadvantage or difference and the unfair distribution of resources, power or health.
Promising Approaches

Intersectional and Post-colonial Frameworks

In the context of mental health policy and practice, biomedical and positivist research paradigms have dominated the field. We suggest that these frameworks are inadequate for surfacing inequities and their role in mental health, and we proffer that the application of intersectional knowledge to policy and practice is critical for addressing social inequities in mental health.

Thus, feminist intersectional approaches to research, which theorize and understand social and structural inequities to be the result of interlocking and overlapping experiences of privilege and oppression, are the most useful for understanding mental health in its intersections with social inequities. Intersectional theory argues:

that gender, race, ethnicity, sexuality, and class are mutually constitutive; that they intersect in the lived experiences of those who occupy and negotiate different social locations in systems of power in the health care system; and that health inequities are produced by racism, gender inequality, and class relations. (Morgen, 2006, p. 398)

Feminist intersectionality and postcolonial scholars share a common interest in social justice, critical inquiry, structural analysis and social context, with a particular focus on power relations, reflexivity, social change and multiple and intersecting social inequities. In addition, postcolonial frameworks value the integration of indigenous knowledges into the research process and the endeavor of knowledge production. Thus, feminist intersectional and post-colonial frameworks embody the principles outlined above by foregrounding the role of historical, political and social contexts in mental health inequities, and by centering lived experience and reflexivity as critical to theorizing and practice.

In sum, as we continue to strive for better and more fulsome understandings of the ways in which social inequities interact with mental health it is necessary to acknowledge the critical role that constructivist research paradigms can offer to this understanding and to take a moral and political stance that affirms social justice as a legitimate driver of research, policy and practice in mental health.
References


Endnotes

i For more information, see http://www.socialinequities.ca.

ii The World Café methodology involves a set of concurrent roundtable discussions focused on a set of questions. It allows for multi-layered discussions that build upon one another (Brown & Isaacs, 2005).

iii Participants in the World Café were all co-investigators of the CGSM working in one of five research theme groups. They were asked the following questions:

1. What are you most interested in with regards to exploring social inequities in the field of mental health?

2. How can the literature review and critique best inform your theme group’s work?

3. What type of evidence would be most useful to your theme group?

4. Which bodies of literature or sources of information would be valuable to include in the review (e.g., government reports, grey literatures, databases, disciplinary parameters such as the social sciences, public health, health care, etc.)?

iv In the reference list articles marked with an * are those that address mental health. Underlined articles were used to write this report but were not part of the scoping review. All other articles were part of the scoping review.

v One reviewer was a mid-career scholar with a PhD in psychology, whose field of study involves using an intersectionality lens to explore the connections among violence, substance use and mental health. The second reviewer was a postdoctoral researcher with a PhD in interdisciplinary studies, whose fields of study are social and political theory, disability, and mad studies.

vi It should be noted that despite the overlap and commonalities between intersectional feminist theory and postcolonial feminist theory, these traditions emerged from different histories. Intersectional feminist theory emerged primarily through the activism and scholarship of Black women in the US (e.g., Crenshaw, 1991), while post-colonial feminism is owed to two histories: that of women activists and scholars in the global south, and that of women activists in First Nations and indigenous communities (e.g., Mohanty, Russo, & Torres, 1991).
The Centre for the Study of Gender, Social Inequities and Mental Health (CGSM) based in the Faculty of Health Sciences at Simon Fraser University and funded by the CIHR’s Institute of Gender and Health, supports collaborative, interdisciplinary, and multi-sectoral teams of researchers and research users from Canada, the United States, Australia, and the United Kingdom. CGSM investigators address gender and social inequities in mental health through the development of innovative research, knowledge exchange and training initiatives.

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SFU Harbour Centre
515 W Hastings, Suite 3277
Vancouver, BC V6B 5K3