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Abstract

The 450-hour advanced practicum took place at Canadian Mental Health Association Muskoka-Parry Sound (CMHAMPS) in Parry Sound, Ontario, in the counselling program and the early intervention program. CMHAMPS has set out to integrate mental health recovery into mental health services as urged by the Mental Health Commission of Canada in an attempt to reform the mental health system. The advanced practicum project was directed by the concept of mental health recovery, as originally conceived of and envisioned by psychiatric consumer/survivors; in light of how recovery is conceived of, and delivered in community mental health services. This entailed research and understanding of the origin of recovery and the original intentions of the paradigm in comparison to how mental health recovery has been implemented in mental health practice with the medical model. The utilization of anti-oppressive social work practice, structural social work practice and anti-sanism helped guide learning on how to form an alliance with mental health service users for personal and broader social change as a social worker without lived experience of madness. Narrative therapy and mindfulness practice were interventions utilized during the advanced practicum through one-to-one counselling and group sessions and are interventions that may complement recovery as envisioned by psychiatric consumer/survivors.

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Chapter 1: Introduction

Canadian Mental Health Association Muskoka-Parry Sound (CMHAMPS) delivers various mental health services in the Muskoka district and the Parry Sound district in Ontario, Canada. The advanced practicum took place in the Parry Sound district, and this thesis report outlines the rationale and learning goals behind the chosen advanced practicum project, reviews literature in connection with the learning goals and foundational questions, and reflects on the learning experience throughout the advanced practicum, and closes with implications for social work practice.

Chapter 1 of the thesis report provides a brief overview of the advanced practicum specific to the hours spent in the counselling and early intervention programs at CMHAMPS. This includes my learning goals established prior to practice and the rationale behind the advanced practicum. Chapter 2 reviews academic literature specific to mental health recovery in light of Canada's neoliberal context, sanism, the psychiatric consumer/survivor movement, and the Mad movement, as well as literature relevant to rural and remote communities in Canada.

Chapter 3 of the thesis report provides an overview of the practicum experience guided by my learning goals and questions and connects to the impact of the medical model on mental health service delivery. This chapter sheds light on the practice of anti-oppression as it relates to multiple social problems and norms for service users. Provided are concrete examples of the use of narrative therapy and mindfulness practice, as well as ethical dilemmas that were experienced prior to and during the advanced practicum.

Overview of the Advanced Practicum

The 450-hour advanced practicum took place at CMHAMPS at the West Parry Sound (WPS) office, where I am employed as a crisis support worker within the crisis-intake program. Due to my employment in the crisis-intake program, the advanced practicum was carried out in two programs distinct from crisis-intake. I chose to complete the advanced practicum in the counselling program (CT) and the early intervention program (EIP) where I provided counselling and co-facilitated group therapy. This role differs from my daily crisis-intake position, as my employment position does not entail longer-term counselling outside of crisis intervention or group therapy. The practicum was supervised by Kathy Harris, the EIP program clinician, who does not work within, nor supervise the crisis-intake program.

As a crisis worker, I provide intake and crisis support in the Parry Sound community, as well as crisis consultations/assessments to the general hospital in Parry Sound, the West Parry Sound Health Centre (WPSHC). In the CT program, I provided one-on-one counselling with service users admitted to CT for 8-12 sessions, and I co-facilitated a mindfulness group every Tuesday morning with a colleague. The service users I saw one-to-one in CT were new cases for me for the purposes of this advanced practicum. In total, I worked one-to-one with five service users. Furthermore, the mindfulness group ran weekly for two hours until January 2020. Within my one-to-one sessions, I utilized knowledge gained by the narrative therapy certificate training course I attended and completed at SickKids Centre for Community Mental Health once per month as part of my placement hours. Furthermore, I worked in the EIP program alongside Kathy Harris, and learned about various methods of practice and interventions for the youth admitted to this program.

Within both CT and EIP, I learned more about anti-oppression in practice and worked toward developing an anti-sanist attitude. To practice anti-sanism, I focused on engaging with service users about the social construction of identity and structural oppression. This initially involved my own critical self-reflection, and I moved toward the practice of mutual learning and moved away from the use of 'expert knowledge' as I wanted to refrain oppressing service users further due to my own social location and power in a therapeutic relationship. By acknowledging that my judgements, biases, and assumptions contribute to oppression, I worked on developing an anti-sanist attitude by respecting and incorporating the knowledge of lived experiences to assist in developing my anti-oppressive social work practice and structural social work practice.

Rationale for the Advanced Practicum Project

The advanced practicum project was influenced by the experiences I have had while working on a clinical crisis team at CMHAMPS in collaboration with the WPSHC in Parry Sound, Ontario. I witnessed many oppressive scenarios, processes and outcomes. For example, observing the impact of involuntary admissions to psychiatric hospitals on service users and how mental health workers are a part of this oppressive process and practice. The advanced practicum project was born out of a complex and multi-layered question: how can I form an alliance with service users for individual and broader social change? I wanted to explore the concept of recovery as originally conceived of and envisioned by psychiatric consumer/survivors in light of how recovery is conceived of and delivered in community mental health services. This involved an understanding of the origin of recovery and the original intentions of the paradigm. Furthermore, this involved learning how CMHAMPS has integrated mental health recovery into policy and practice and whether this integration truly suits the needs of psychiatric consumer/survivors. As mental health recovery is referred to in CMHAMPS (2018) mission

statement, “Canadian Mental Health Association, Muskoka-Parry Sound Branch is committed to hope and recovery through integrated mental health and addiction services” (para. 1), and as CMHAMPS is an organization where the medical model dominates policy, procedures and practice, I questioned, how can I stay true to recovery as envisioned by psychiatric consumer/survivors while working inside the mental health system?

As a social worker who does not have lived experience of madness, my goal was to explore the dominance and practice of sanism in this context and the impact this has on my relationships with service users. In exploring sanism, my intentions were to break down the barriers of individually confined deficit models often visible in medical model approaches, as well as practices that sustain oppression. I predicted that the tension between sanism, anti-oppressive social work practice and medical model approaches could be explored first by surfacing oppressive experiences, then placing oppressive experiences within the social context they derived from. In order to begin exploring these tensions, building rapport with service users through mutual learning, unconditional positive regard, and reciprocity within one-to-one interactions and groups were approaches I predicted would be useful, as well as the use of narrative therapy. This was different in comparison to more dominant treatment-oriented approaches at CMHAMPS, involving the use of diagnostic labeling and medical treatment or structured therapy such as dialectical behaviour therapy or cognitive behaviour therapy. CMHAMPS at the management level was supportive of my learning and application of any evidence-based practice approaches as the CT program allows practitioners to choose their own modality as they see fit with service users.

The advanced practicum experience was an opportunity to explore the writing and knowledge generated by Mad studies and the lived experience and knowledge of psychiatric

consumer/survivors in light of the recovery orientation of community mental health service delivery in northern Ontario. I incorporated the knowledge of lived experience into clinical practice to continue to develop my anti-oppressive social work practice. To develop my anti-oppressive social work practice, I considered various social work interventions throughout my research on mental health recovery. As a social worker who values anti-oppression and structural social work practice, but as someone who does not have lived experience, I asked myself how I can contribute to social change and begin to challenge oppression. I recognized early in my practicum that I could start on a micro level and connect to service users directly, through one-to-one sessions. I predicted that narrative therapy may hold promise to support a recovery approach and social change as envisioned by psychiatric consumer/survivors. Furthermore, I was interested in mindfulness practice both for myself as a clinician and for service users. These two interventions were the primary focus clinically in both CT and EIP.

Advanced Practicum Questions and Learning Goals

As I am considered an 'outsider' to madness as I do not have lived experience, I developed three concrete questions to help guide my learning in respect of the lived experience and knowledge of psychiatric consumer/survivors and the Mad movement:

1. How can one stay true to 'recovery' as envisioned by psychiatric consumer/survivors and the Mad movement while working inside the mental health system in northern Ontario?
2. How does sanism impact my relationship with service users?
3. How can a practitioner without lived experience of 'madness' facilitate anti-oppressive social work practice and resist sanism in the mental health system?

From these foundational questions, four learning goals were established as follows:

1) Generate practice knowledge from Mad studies.

2) Understand how recovery is envisioned by the Mad movement and the psychiatric consumer/survivor movement.
3) Understand how recovery is conceptualized and applied in community mental health by mainstream practitioners.
4) Further my anti-oppressive social work practice by incorporating the knowledge and lived experiences of psychiatric consumer/survivors and the Mad movement.

Social Location

The rationale outlined above stems directly from my own social location and the recognizance of my social privilege. I am a 26-year-old Caucasian woman living in a rural area in Ontario. I am a third-generation Canadian citizen, and I recognize my settler identity as a Caucasian woman with significant socioeconomic privilege living in a rural area in Ontario.

As stated in the above paragraphs, the question of how I can form an alliance with service users for individual and broader social change aided in the development of the advanced practicum project. In order to begin exploring this question, I contended that my social location must be stated, explored and reflected upon in order to gain knowledge of how it influences my learning, as well as my practice as a social worker.

The concept of social location is linked to structural social work practice as it refers to locating oneself socially and within the structures of society (Heron, 2005). Self-awareness is highly important in understanding how privilege can perpetuate oppression and how to fight against oppression, despite one's social location. Self-reflection supports the development of self-awareness. Heron (2005) explains that she teaches her students to read and write reflectively, and stated,

> I seek to deepen students' analysis of how issues related to power and oppression infiltrate their interactions with clients, and their own connectedness to these issues: i.e., how power and oppression shape their sense of self and their approach to practice (p. 341).

This type of reflection Heron (2005) refers to relates to how oppression exists within client interactions and practice. Stating my social location prior to reflection is important in order to understand how sanism, among other forms of oppression such as racism and sexism, could impact my relationship with service users.

I recognize my own prejudice toward the client population I engage with who are labelled with 'serious mental illness.' I acknowledge that at times, I fear or cannot relate to the individuals I work with, as I do not have lived experience of 'madness'. Although this fear may be an innate response, I know this also stems from a lack of knowledge and understanding of madness, as well as due to sanism. This is a subject I approach with caution and sensitivity as it is something that impacts my practice daily. At times, it is difficult to relate to the experiences of service users socio-economically, due to my lack of experience of oppression in the form of madness, as well as due to my economic advantage in comparison to those living in poverty. Furthermore, my practice and prejudice are highly impacted by my settler identity in a northern Ontario city. This settler identity impacted my learning opportunities in a number of ways. For example, there are multiple Aboriginal service users who wish to discontinue services in the Aboriginal program at CMHAMPS due to their personal relationships with staff. Many of these service users inquire about 'mainstream' programming, which is where my advanced practicum took place, in EIP and CT. Aboriginal service users often refuse mainstream services after experiencing the dominating whiteness of our teams. This indicates how my white privilege

contributes to oppression, as well decreased opportunities to form an allyship with service users during and following the advanced practicum. Furthermore, my identity as a woman brings forth another set of challenges, such as working with men who are perpetrators of violence toward women. I have encountered many situations where I have had preconceived notions made up of fear and mistrust toward this population from my own experiences of oppression as a woman. This has resulted in missed opportunities to explore the lives of many men who are also impacted by sanism or structural oppression.

Recognizing my social location is important, especially in relation to anti-oppressive social work practice, as this recognition outlines how I contribute to oppression, and more specifically, practice sanism. This practicum was a form of critical self-reflection as I explored sanism and how this impacts my relationship with service users. Furthermore, the focus of this practicum was to obtain knowledge generated in Mad studies, specific to sanism and recovery, and utilize it in my workplace for personal growth in consideration of my social location. I predicted that this learning would heighten my own self-awareness, which is essential in order to practice anti-oppression as a social worker who contributes to oppression herself. Where I sit socially and economically, as well as without any lived experience of madness, puts me in a position where I could dominate a therapeutic relationship, and thus, contribute to the oppression already being experienced by service users.

As both my own sense of self and my professional interventions are shaped by oppression, I predicted my relationships with psychiatric consumer/survivors would be strongly influenced by this reality. I understood that I needed to gain more knowledge about the experiences of psychiatric consumer/survivors through research and practice. As it was my intolerance to injustice that led me to social work practice, I vowed to uncover my own biases,

prejudice and practice of oppression. This involved working to relate to those I am working with, to look beyond their diagnoses and finding the person underneath through mutual learning and reciprocity while listening or observing personal narratives. With this recognition of identity and social location, self-reflection took place throughout the entirety of the advanced practicum project in order to learn how to fight against sanism, evident throughout chapter 3 of this report. Ethically speaking, my identity and social location posed an ethical dilemma for this advanced practicum project, as will be explored herein.

Professional Ethics

During the completion of the advanced practicum hours, prior to the advanced practicum hours, and during the writing of the thesis report, professional and ethical conduct was upheld in dedication to the Canadian Association of Social Workers (CASW), and as an active member of the Ontario College of Social Workers and Social Service Workers (OCSWSSW).

Multiple ethical dilemmas arose during the unfolding of the advanced practicum as I do not have the lived experience of 'madness'. Remaining true to the Mad movement proved to be challenging as I do not identify as a psychiatric consumer/survivor or as a Mad activist. Furthermore, working in a community mental health treatment setting dominated by medical model approaches, while furthering my knowledge on recovery as envisioned by psychiatric consumer/survivors, proved to be an ethical dilemma in and of itself.

As a student, and as an employee of CMHAMPS, I recognized at the beginning of my advanced practicum that I have an opportunity to learn about some of the most deeply rooted structural issues, such as neoliberalism, that influence our practices and policies. These were issues I was able to bring forth in supervision and in self-reflection. I reflected by referring to CASW professional standards, as well as my own personal values. I learned more about how I

can work in a way that respects the knowledge generated from the psychiatric consumer/survivor movement and the Mad movement, as well as the lived experiences of service users. I would consider the mutual learning that took place in session and the knowledge gained by listening to the lived experience of service users as a way that I explored these ethical dilemmas. I researched and contemplated what approaches are complementary for 'recovery' as envisioned by psychiatric consumer/survivors and the Mad movement, as well as whether or not these approaches can be carried out in community mental health. The reflection portion of the thesis report explores these ethical dilemmas and the attempts made to rationalize and solve them throughout the advanced practicum.

Due to my own privilege and social location, I continue to practice with sensitivity in relation to the power I hold within my interactions. I recognize my contribution to oppression as I continue to work in a treatment setting in the mental health sector where there are clear power differences between practitioners and service users and where medical model terminology is prominent. Ethical dilemmas were frequent during the advanced practicum due to the overarching presence and pressure dominance of the medical model, especially when one begins to explore the tension between anti-oppressive social work and sanism in mental health services. As I work directly with WPSHC in all of the programs I am associated with through employment and my practicum, this thesis report will reflect on oppressive experiences and ethical dilemmas I initially observed while working on the crisis-intake team, with extended reflection on my observations and learning during advanced practicum in CT and EIP. The thesis report explores how the mental health sector in Canada holds two competing paradigms and how these are conceptualized in practice and the possibility for recovery in northern and rural areas in Ontario.

Key Terms

My place of employment and the advanced practicum is within the community mental health sector in collaboration with psychiatry and primary health care. These engagements include the Family Health Team, West Parry Sound Health Center, and the Northern Psychiatric Outreach Program. Throughout this proposal, there is terminology and language used by my employer. I recognize and respect that the terms used in this thesis report, such as 'psychosis' or 'mental illness,' reflect the medical model which contrasts the learning objectives outlined above. Furthermore, the term 'service user' will be used throughout to describe individuals receiving service at CMHAMPS, although I recognize this term may reflect a pro-psychiatry position (Burstow & LeFrançois, 2014). The section below will highlight key terms. Additionally, the sources used below are primarily Canadian scholars to reflect economic, political and social concerns related to this topic in a Canadian neoliberal context.

Medical Model. The medical model refers to 'mental illness' as a detectable brain state, thought of as a hormonal imbalance, deficiency or excess of neurotransmitters, or from genetics (Thachuk, 2011). The term mental illness typically reflects the medical model, as the term illness marks mental illness as a disease and is objectively understood. The medicalization of mental illness is disputed by Mad studies and the psychiatric/consumer survivor movement as it emphasizes marking an individual physically as "other," rather than an examination of the biological, psychological and social aspects of a person's life (Thachuk, 2011). The medical model is used in many practices, such as psychiatry and psychology, however there are other ways to view mental health or madness from a social work perspective (Poole et al., 2012). Although a diagnosis related to a medical condition may make their condition legitimized, this

can be problematic and further stigmatizing without including environmental factors (Thachuk, 2011).

Psychiatric consumer/survivor movement. In the 1960s, consumer/survivors collaborated on shared concerns about forced institutionalization, medical treatments and abuse of human rights (Poole et al., 2012). The Mental Patients Association was formed in Vancouver, Canada in the 1970s, which provided peer support and was made up of ex-patients of psychiatry (LeFrançois et al., 2013). This association was considered the first formal group of psychiatric consumer/survivors (LeFrançois et al., 2013). New terms were coined with this movement, such as 'mentalism' and 'sanism' (Poole et al., 2012). Ex-patient groups, disability rights' movements and feminists proposed important critiques of medical discourse in mental health (Tomes, 2006). Tomes (2006) recalls patient movements dating back to the nineteenth century and regards Elizabeth Packer as an important figure in this era.

Mad and Madness. "Mad" can be defined as, "an umbrella term to represent a diversity of identities, used in place of naming all of the different identities that describe people who have been labelled and treated as crazy" (i.e., consumer, survivor, ex-patient) (LeFrançois et al., 2013, p.10). With what social institutions now refer to as mental illness, the term madness was replaced with the emergence of the psychiatric field to challenge the clinical language that oppresses madness (LeBlanc & Kinsella, 2016). Terminology to express the experiences of those living in emotional or mental diversity include; lunatic, disabled, deviant, psychiatric survivor, crazy and Mad (LeBlanc & Kinsella, 2016).

Mad Studies. Mad studies is an emerging discipline built by the knowledge and enquiry of psychiatric consumer/survivors, the Mad movement and anti-psychiatry approaches (LeFrançois et al., 2013). Mad studies highlights the medicalization of 'mental health,' and links this to

broader social problems, such as neoliberalism (LeFrançois et al., 2013). Mad studies recognizes societal contribution to emotional distress and oppression toward Mad people through psychiatric domination (LeFrançois et al., 2013). Mad studies explores the lived experiences of psychiatric consumer/survivors, as well as Mad experiences and understandings of madness (LeFrançois et al., 2013). Mad studies contends that Mad people are at the centre of their own lived experience narratives and these experiences vary across cultures (LeFrançois et al., 2013).

Sanism. Sanism is defined as a form of oppression that can lead to negative stereotyping. Sanism refers to knowledge that can contribute to oppression toward Mad people (Gewurtz et al., 2016). It has been suggested that sanism could be a reason for the exclusion of psychiatric consumer/survivor and Mad perspectives in mental health knowledge (Gewurtz et al., 2016). Poole et al. (2012) suggest that stigma is an outward manifestation, caused by sanist beliefs and practices, and that we must focus on both occurrences, rather than just the outcome of sanism, which is stigma.

Mental health Recovery. The term recovery originated from the psychiatric consumer/survivor movement, combined in collaboration with professional mental health sectors (Morrow, 2013). From the psychiatric consumer/survivor movement, the idea of recovery was advocated for to challenge the medicalization of mental health and the power of medical professionals, such as psychiatrists (Morrow, 2013). Mental health recovery has been adopted by many mental health workers as a model, to recover from ‘illness’ (Poole et al., 2012). Professionals in the mental health field have used this approach for the needs they have observed among consumers, and is now considered a model as opposed to the paradigm shift advocated for by psychiatric consumer/survivors (Morrow, 2013).

Chapter 2: Literature Review

Mental health services in Canada have adopted a concept known as ‘recovery,’ which originated from the psychiatric consumer/survivor movement (Morrow & Weisser, 2012). While the concept of recovery originated as a shift in ideology to reform the mental health system in Canada, medical model influence has overshadowed the core values of the recovery paradigm (Adame & Knudson, 2008). The literature review will explore the concept of mental health recovery from its historical roots within the psychiatric consumer/survivor movement, to how it has been conceptualized and practiced within mental health service delivery in Canada. Specifically, the anti-psychiatry movement and its link to the emerging discipline of Mad studies, as well as the psychiatric consumer/survivor movement, will be discussed to provide context of the original meaning of mental health recovery. These movements intersect and overlap on many points; however, they are components of the psychiatric consumer/survivor movement. Moreover, narrative therapy as a social work intervention will be reviewed in its effectiveness in shifting therapy toward a recovery approach as envisioned by psychiatric consumer/survivors and Mad activists. The impact of sanism on anti-oppressive social work practice and structural social work practice will be examined. The literature review was conducted through online journal access and books retrieved from the Laurentian University library, my workplace library, and from my advanced practicum supervisor. As the advanced practicum took place in Parry Sound, Ontario, the first section of the literature review will summarize and discuss challenges within the mental health sector in northern Canada, and following this, in a northern Ontario context.

Mental Health in the Northern and Rural Canadian Context

Individuals and families that reside in rural areas of Canada are at risk of experiencing barriers to mental health services (Ryan-Nicholls & Haggarty, 2007). When accessed, service users face limitations and can be subjected to mistreatment due to a lack of services and practitioners. Ryan-Nicholls and Haggarty (2007) reflect on the differences between northern and southern Canada and argue that there are major disparities between the geographic locations, with a lack of resources for residents living in northern Canada. For example, in Parry Sound, Ontario, those who are involuntarily admitted to a schedule one facility on a 'Form 1' are sent to Waypoint Centre for Mental Health for psychiatric treatment. As psychiatry is the only option for further mental health assessment, individuals are involuntarily sent to where services are available. This is an example of the limitations and lack of services in northern Ontario.

Ryan-Nicholls and Haggarty (2007) argue that social policy in northern Canada does not reflect northern needs, rather, they are reflective of southern and more urban areas of Canada. Newer developments, such as access to telemedicine, provides service users an opportunity to communicate through Ontario Telemedicine Network with medical professionals in Ontario. However, it is often psychiatry that is utilized through this service in community mental health agencies. Although these lack of resources highlights a need for more services, the introduction of telemedicine also reflects medical model approaches to mental health services. What is considered the traditional mental health system does not implement or consider the perspectives of service users, and this is visible through medical model domination in the form of psychiatry (Ryan-Nicholls & Haggarty, 2007).

Some barriers that exist in current mental health care services in northern Canada include policy issues, access issues, provider shortages and limited consumer/survivor involvement in decision making (Ryan-Nicholls & Haggarty, 2007). In terms of policy issues, practitioners experience a lack of education and must work within certain program mandates in northern Canada (Ryan-Nicholls & Haggarty, 2007). Access issues in northern Canada include barriers to transportation to more urban areas where mental health services are being delivered, as well as barriers to psychiatry (Ryan-Nicholls & Haggarty, 2007). Furthermore, limited consumer/survivor involvement in decision making in northern Canada results in a lack of effectiveness of services as programs continue to rely on medical approaches, such as psychiatry (Ryan-Nicholls & Haggarty, 2007).

The Ontario Canadian Mental Health Association (CMHA) provides a comprehensive report on the definition and health status of "northern Ontario." The Local Health Integration Networks (LHIN) that cover the geographic location of northern Ontario includes the North East and the North West LHIN. Studies show that northern Ontario has a higher reported rate of 'poor mental health' (Canadian Mental Health Association, 2018). In 2004/2005, in northern Ontario, the use of emergency rooms for mental health reasons was more than double the Ontario average (Canadian Mental Health Association, 2018). The Ministry of Health and Long-Term Care reported that only 5 percent of Ontario physicians' practice in rural areas in Ontario, which does not meet the needs of the population of these communities (Canadian Mental Health Association, 2018). Some rural communities experience a shortage of healthcare providers; for example, Ryan-Nicholls and Haggarty (2007) report, "fewer than 1 physician existed per 1,000 rural residents, compared to 2 or more physicians per 1,000 urban residents" (p. 4).

There are challenges in recruiting mental health workers in northern Ontario regions (Canadian Mental Health Association, 2018). Raphael (2004) hypothesizes that unequal jurisdictions spend less money, and in turn, they have weaker infrastructures. He reports that in Canada, there has been little focus on economic inequality in various jurisdictions beyond documentation (Raphael, 2004). A lack of resources results in weaker infrastructure, which damages the health of people within jurisdictions such as northern Ontario. With a weaker infrastructure comes higher rates of poverty, impacting service users of mental health. With these higher rates of poverty comes a greater need for services in an area that lacks resources, resulting in longer waitlists, and barriers to services such as provider shortages. These structural issues put mental health workers at further risk of contributing to oppression in the form of sanism due to working within mental health services that are overpowered by the medical model.

Sanism

Sanism is a deeply rooted oppression in the form of ‘othering’ of those diagnosed with a mental illness (Didyk, 2016; Morrow & Weisser, 2012; Poole et al., 2012; Procknow, 2017). This form of oppression has become normalized and deeply rooted in many disciplines and institutions, including social work (Poole et al., 2012). Sanism is practiced unconsciously and continues to exist due to a level of tolerance by society (Procknow, 2017). Sanism is connected to the medical model as it has been formed as a social norm to diagnose, label and treat mental illness in order to keep society ‘safe’ or ‘out of harm's way’ (Meerai et al., 2016). Workers in mental health care are then at risk of sanist attitudes due to medical model dominance (Meerai et al., 2016).

Perlin (1992) explores the roots of sanism, arguing that ideas around ‘mental illness’ are deeply rooted in evil and sin, marking individuals who were considered unreasonable, or who had lost control of themselves. There are many ways in which sanism, sexism and racism intersect (Morrow et al., 2011; Perlin, 1992). For example, historically and present day, many women are considered mentally ill postpartum, which is dismissive of the economic and cultural actualities that women face (Leonardo, 2012; Perlin, 1992). This reflects the medicalization and victimization women experience as they are viewed as mentally ill, such as through the common practice of labeling of postpartum depression and the use of screening tools and antidepressants (Cosgrove et al., 2018). There is a belief that those who are deemed mentally ill are dangerous and this is a form of prejudice that lacks evidence to support this in comparison to those who are not considered mentally ill (Large & Ryan, 2012). Perlin (1992) states, “neither expert witness nor mental health professionals are immune from the myths’ powers and sway” (p. 397). This is of major concern for the field of social work, as mental health practitioners are at risk of perpetuating this form of prejudice or sanism. In turn, sanism is also of major concern for institutions which are considered anti-oppressive or intend to practice anti-oppression (Morrow & Weisser, 2012).

Perlin (1992) regards sanism as a form of oppression that can be more troublesome than other forms of oppression, such as racism or sexism, as it is socially acceptable, as well as highly invisible. This is a stereotype so deeply rooted in society. Perlin (1992) refers to it as ‘insidious’ as it is based on superstition and myth. The danger with sanism is that it is embedded in large institutions, such as law, medicine, legislation, and academics (Large & Ryan, 2012; Perlin, 1992). In order to understand how this oppression is deeply rooted in many of society's institutions, intersectionalities of race, gender, age, disability and class need to be recognized and

connected in how we define ‘madness’ (Diamond, 2013). Without any visibility within politics, Morrow and Weisser (2012) argue that those deemed mentally ill are marginalized and face difficulty in advocating for change. The systems of our society in which sanism flourishes must be confronted and the roots of sanism must be uncovered in order to advocate for social change. It is those who identify as ‘Mad’ who are often the one’s fighting against sanism and advocating for change, and this is not enough for real change to occur due to bureaucratic power relations in the mental health sector (Diamond, 2013).

Perlin (1992) explores how labels can be stigmatizing and discriminatory as they often hold negative associations, which many individuals can begin to internalize. These labels are used to categorize deviation from ‘normal behaviour’ (Large & Ryan, 2012). These labels and stereotypes are visible within political and religious theories, which have then socially validated these distorted understandings of ‘mental illness,’ resulting in oppression. Although there are some members of the Mad movement who do not resist biological components of madness, or accept and identify with biology or genetics, their main focus is on the structures in society that oppress them (Diamond, 2013). Sanism as a deeply rooted oppression connects to the medical model due to the labelling and diagnosing of madness, as well as the structural oppression that exists in many powerful institutions. Social movements, such as the anti-psychiatry movement, have strong views on the medicalization of madness due to its pathologizing nature.

Antipsychiatry Movement in Canada

The institution of psychiatry was rebelled against with other social movements in the 1960s, such as feminist, the gay liberation movement and civil rights movements (Everett, 2012; Rissmiller & Rissmiller, 2006). For example, the gay liberation movement from 1968-1980 became interconnected with the anti-psychiatry movement due to the conceptualization and

diagnosis of homosexuality as an illness (Lewis, 2016). Burstow and LeFrançois (2014) argue that psychiatry is an institution that attacks everyone, as it attempts to define and pathologize "everyday life." Forced admissions into institutions or asylums led to the resistance and crafted a group of individuals who confronted the abuse they had endured (Rissmiller & Rissmiller, 2006). The resistance toward psychiatry consists of critiques of the Diagnostic Statistical Manual (DSM) and uncovering sanism. Furthermore, the resistance challenges the dominance of neoliberalism on psychiatric consumer/survivors, Mad people, and service users (Burstow & LeFrançois, 2014). Burstow (2014) contends that anti-psychiatry activists are fighting against thousands of years of injustice from those who are deemed as different or deviant. Burstow and LeFrançois (2014) hold that the resistance of psychiatry is a regime that orders attention and support.

The anti-psychiatry movement assisted in the unmasking of other oppressive social institutions such as patriarchy (Burstow & LeFrançois, 2014). Burstow and LeFrançois (2014) write from a Canadian perspective. Burstow (2014) explains that anti-psychiatry is a different perspective from those who critique psychiatry, as the goal of anti-psychiatry is to abolish psychiatry completely. Critics of psychiatry, who also contributed to *Psychiatry Disrupted: Theorizing Resistance and Crafting the Revolution,* are not all in favour of abolishing the institution of psychiatry, but do critique the dominance of the field (Burstow, 2014). Activism in the 1970s emerged as ex-patients voiced their negative experiences with psychiatry (Everett, 2000; Joseph, 2013). David Cooper coined the term anti-psychiatry after the movement had already been initiated, which then grew internationally by Thomas Szasz in the United States of America, R. D. Laing in Britain, Michael Foucault in France and Franco Basaglia in Italy (Rissmiller & Rissmiller, 2006). Thomas Szasz viewed psychiatry as a form of social control by

the state (Everett, 2000). Scull (2015) explores the term ‘psychiatry,’ which alluded to mad doctors who specialized and managed madness. The term ‘psychiatrist’ became a preferred term for those who managed ‘mental illness’ (Scull, 2015). Defining mental illness stems from cultural and social order and its link to religious and scientific domains (Scull, 2015). This is visible in modern day mental health community care as madness continues to be medicalized through labelling it as a mental illness or as a disorder (Procknow, 2017).

As an anti-psychiatry activist, Bonnie Burstow made a significant contribution to this field. Burstow’s (2019) latest book, *The Revolt Against Psychiatry: A Counterhegemonic Dialogue,* analyzes the validity of psychiatry, while taking this further by exploring the need for a paradigm shift and collaboration with Mad activists. Burstow (2019) argued that psychiatry is a field that lacks scientific validity. Burstow (2019) further argued that vast state power runs the psychiatry field, and states that it is self-serving and violates people’s rights due to harmful treatments. Burstow (2019) stated that her book is about a social justice movement, providing suggestions and strategies for activism in challenging psychiatry. Bonnie Burstow passed away on January 4, 2020, and this book was her last publication.

Diamond (2013) critiques the anti-psychiatry movement for ignoring the positive experiences with psychiatry in favour of abolishing the system entirely. Diamond (2013) further argues that the anti-psychiatry movement is far removed from lived experiences due to the roots of the movement coming from academia and professionals (Diamond, 2013). Furthermore, Diamond (2013) brings forth an important point that while surviving under a capitalist welfare system, or neoliberalist values, abolishing psychiatry completely will impact those receiving social support through disability and social assistance programs, as those who qualify for Ontario Disability Support Program (ODSP) will not have access to this and will then face financial

burdens, as these social welfare programs depend on proof of disability and the inability to contribute to the workforce. This is an example of the dominance of psychiatry and the field's influence on the welfare state and service users, bringing forth challenges for agencies and mental health practitioners who wish to practice anti-oppression due to the strength of institutional and structural oppression. Burstow (2014) argues that there is no easy solution to this issue, due to the fact that many individuals rely on psychiatry for treatment as well as social assistance.

Although there are psychiatric consumer/survivor activists within the anti-psychiatry movement, consumer/survivors are not united behind this movement due to the affiliation being from academia and professionals. Furthermore, consumer/survivors hold diverse opinions on the field of psychiatry, with some who envision working in collaboration with psychiatrists, and who have had positive experiences within the field of psychiatry. However, these two movements do have a significant shared value that the medical model dominates mental health services and a paradigm shift is vital.

Psychiatric Consumer/Survivor Movement in Canada

The following section will review literature specific to the origin of the psychiatric consumer/survivor movement and perspectives documented from psychiatric consumer/survivors related to their experiences in the mental health system and their stance toward the medicalization of mental illness. The concept of recovery will be further introduced with its roots in the psychiatric consumer/survivor movement.

The term psychiatric consumer/survivor is used to refer to those who have been hospitalized for mental illness or diagnosed with a mental illness and who participate or identify as a psychiatric consumer/survivor or activist of the movement (Nelson et al., 1998).

Consumer/survivor is used instead of the term's 'client' or 'patient' in light of those who have self-identified and resist these popular medicalized terms (Nelson et al., 1998). In contrast, there are some individuals who do not wish to identify as a 'consumer' or as a 'survivor' (Nelson et al., 1998). Burstow (2013) explains that the term consumer/survivor has become so popular that it has been adopted by many community members, as well as the Canadian government. Burstow (2013) argues that terms such as this remind her of the word 'patient' and although these new terms may seem progressive, they do not solve nor separate the issues within the mental health system and psychiatry. Burstow (2013) states, "they enable us to keep the peace all right, but at the expense of forgetting we are at war" (p. 88). She argues that using the word 'and' between consumers *and* survivors is a way to respect that these two groups are in fact very different (Burstow, 2013). Furthermore, there are layers of challenges for the term 'consumer'. 'Consumers' may be recognized as individuals who are working within the mental health system and are in some ways viewed as individuals who have the power to make changes within the mental health system (Burstow, 2013). In contrast, others see this involvement in the mental health system as a threat and as contradicting the psychiatric consumer/survivor movement, which does not address true systemic oppression (Diamond, 2013). The term consumer, however, can be conceived as a reflection of market consumerism and reflect neoliberalist values, contradicting the values of the psychiatric consumer/survivor movement in challenging medical model approaches and neoliberalist values. Furthermore, the use of consumer/survivors does not account for those who have experienced madness but who have not been in contact with the mental health system.

The psychiatric consumer/survivor movement is made up of four groups that are distinct from one another, yet related through shared beliefs and values, including Mad, anti-psychiatry,

and psychiatric consumer/survivors (Chan, 2019). The psychiatric consumer/survivor movement is worldwide and aims to give a voice to those who have experienced madness and the impact of the mental health system (Everett, 2000). Furthermore, the psychiatric consumer/survivor movement aims to reduce mental health service use, challenging the theories and interventions of psychiatry (Everett, 2000). Tomes (2006) contends that the movement stemmed from the knowledge and works of the anti-psychiatry movement. Early writings of anti-psychiatry scholars viewed mental illness not as an illness, but rather as an alternative state of being (Tomes, 2006). The movement is made up of various forms of activism, with some individuals and groups at the local level to fight against social injustice, and others who do not engage in activism but support the goals of the movement, such as mental health service reformation (Adame & Knudson, 2008). Forms of political activism in Canada from consumer/survivors include sharing experiences within the mental health system with others, as well as listening to stories of experiences, forming roots for protest and social action (Everett, 2000). This activism has mobilized many other activists and has influenced consumer/survivor roles in delivery of mental health services (Daya et al., 2019). Daya et al. (2019) argue that although consumer/survivors are now employed in mental health service agencies and participate in various projects, there are many different perspectives of the effectiveness of this from consumer/survivors. This is due to the fact that every consumer/survivor has had a different experience with madness and with services (Daya et al., 2019). Some of these perspectives include positive treatment experiences by affirming their experiences and benefits from medication (Daya et al., 2019). In opposition, are those consumer/survivors who have had negative treatment experiences through forced institutionalization and diagnostic labelling (Daya et al., 2019). Diamond (2013) suggests that consumer/survivors are part of a movement that

cannot be easily defined; however, this movement is at the core of the political community that is made up by anti-psychiatry, Mad, and psychiatric consumer/survivor constituencies.

The medical model approach narrows in on individual deficit, dismissing consideration of the political, social and economic implications on various individuals and groups in society (Adame & Knudson, 2008). Adame and Knudson (2008) explore the concept of 'the empty self,' which reflects a medical model of mental illness bounded to individualistic views of one's self in the absence of community and shared meaning among consumer/survivor experiences (Adame & Knudson, 2008). Adame and Knudson (2008) interview four psychiatric consumer/survivors in exploration of the concept of recovery, and asked participants 'what it means to live a good life' as opposed to how consumer/survivors define recovery. The feedback of one consumer/survivor was:

> The good life isn't a personal expression… That's already seeing it as a commodity that you can achieve...Look at the amount of poverty that our economy tolerates. The kind of serious social problems that aren't being addressed. Like domestic violence, and violence against women, and environmental problems. I mean these are all, to me, bound up in the idea of what is a good life. It's that it's not an individual thing. It's that it's a group thing. A social thing (p. 156).

This participant relates 'the good life' back to the social impact on lives everywhere, as well as neoliberalism, in the context of the United States, where this study took place. Adame and Knudson (2008) argue that the psychiatric consumer/survivor movement is a movement that allows individuals to find their own personal mastery to define their lives outside of 'mental illness' or 'recovery.' The activism of consumer/survivors represents both personal healing, as well as broader social change.

Lee (2013) captures five written narratives of Canadian psychiatric consumer/survivors. Lee (2013) explores the medical model and the uncovering of the pain it has caused on various written narratives, for example, the pain of social isolation, which is worsened by the medical model of mental illness. Lee (2013) reflects on one consumer/survivor narrative of an individual who spent time in the hospital where she was told she lacked insight into her mental health owing to non-compliance with medication. Lee (2013) explores the committal of consumer/survivors for psychiatric treatment and the loss of freedom that comes with this. Although there exist individuals who attend the hospital voluntarily, Lee (2013) questions if this is a result of manipulation and powerlessness, due to lack of resources outside of psychiatry.

Lee (2013) explains that for almost all psychiatric consumer/survivors, self-determination is vital for recovery and this has been denied in mental health care due to the idea that those who are deemed mentally ill are not rational. This is accepted in practice and often emphasized when individuals are reentering the hospital, as discharge plans do not consider the vast differences between life inside the hospital versus outside of the hospital (Lee, 2013). This puts mental health workers at risk of oppressing this population further as it can confirm biased opinions that a service user is ill and unable to manage on their own. This is also an example of how service users and consumer/survivors are at risk of internalizing the perception of dominant cultural views and norms (Mead et al., 2001). Lee (2013) argues that throughout her study, many consumer/survivors reported that their experiences with peers in hospital as positive and that they helped their experiences of distress more than the helping professionals. This mutual support can be considered a method of survival in these times, when consumer/survivors are feeling scared and alone. As those who have been labelled as mentally ill have become victims of social exclusion, Mead et al. (2013) argues that encouraging peer workers to resist the social

and cultural influences of madness can help consumer/survivors work through their complex experiences with the support of someone else who has lived experience. This is important in moving away from the medical model, as the problems of our society cannot only be answered through looking at biological components. Challenging the dominance of the medical model is valued by psychiatric consumer/survivors, as well as for individuals who identify as "Mad" through a newer constituency, the Mad Movement, which evolved out of the psychiatric consumer/survivor movement.

Mad Movement/Mad Studies

Many consumer/survivors today self-identify as "Mad" (LeBlanc & Kinsella, 2016). The Mad movement recovered the word Mad, as activists and consumer/survivors chose to self-identify, much like the word Queer in the LGBTQ2S movement (LeBlanc & Kinsella, 2016). The reason for uncovering this term was due to the oppression felt by this population labelled as "crazy" (Diamond, 2013). Reville (2013) introduces various words he has coined himself due to his own experience as a self-identified psychiatric consumer/survivor and Mad person who is working at Ryerson University in Mad studies. He coined various terms, such as "Mad positive," defined as, "someone who does not identify as Mad but supports the goals of those who do" (p. 170).

The Mad movement was formulated in the 1960s in Vancouver, Canada, as part of the 'Mental Patients Liberation Movement' (Didyk, 2016). This movement was the cornerstone of Mad studies, which incorporates the narratives of psychiatric consumer/survivors, anti-psychiatry approaches, and activism in Canada (LeFrançois et al., 2013). During the 19th century, Starkman (2013) argues that self-help was the only resource for emotional distress, which was utilized among all communities. This was until doctors, teachers, and lawyers

proclaimed a certain expert position, backed up by scientific claims and complex language (Starkman, 2013). The development of the Mad movement involved both professionals in the mental health system and ex-patients due to the tension that existed between these two groups (Starkman, 2013). This movement is connected to feminist movements that existed prior to and during this era, as the idea that the mind was connected to physiological symptoms gained popularity as women who presented as 'neurotic' were considered 'hysteric' (Starkman, 2013). Furthermore, Starkman (2013) highlights the importance of the gay liberation movement as individuals who identified as homosexual were considered mentally ill.

Although the Mad movement originated from a relationship between mental health practitioners and psychiatric consumer/survivors, this relationship ended when consumer/survivors began to feel invalidated, as community members began to utilize psychiatry for their concerns (Starkman, 2013). Following this relationship, consumer/survivors created self-help groups to challenge neoliberalism by removing any form of power or hierarchy in their groups (Starkman, 2013). Starkman (2013) argues that many groups in Canada are in this 'second phase' of activism, with a third phase emerging where psychiatric consumer/survivors have received funding for such groups. However, the lack of structure and hierarchy within these groups have made it difficult to manage this money. Starkman (2013) concludes that there is no complete answer to whether psychiatric consumer/survivors can work together with helping professionals within respect, and in light of the Mad movement.

Psychiatric consumer/survivors are considered victims of biomedical claims, but not victims of their 'illness' or 'madness' (Starkman, 2013). Mad studies and the Mad movement challenge the dominance of the medical model in 'mental health' in that it "fixes" above all else, in a capitalist system that intends to correct Mad people (LeFrançois et al., 2013). Madness

resists ‘sanism’ through self-identification and resistance to medical terms such as ‘mental illness’ or ‘disorder’ (LeFrançois et al., 2013). This term is meant to resist pathologizing clinical labels and the medical model in order to promote social justice (LeFrançois et al., 2013).

As the medical model continues to dominate mental health services, psychiatric consumer/survivor narratives and Mad people’s narratives continue to be overshadowed, which limits the social understanding and interpretation of lived experiences (LeFrançois et al., 2013). Procknow (2017) highlights this lack of inclusion by stating, “Mad citizens are rendered unintelligible beings only to be spoken and written about” (p. 7). Although the medical model is used in mental health practice, diagnoses of mental illnesses lack clinical value due to the lack of support of biomedical claims in research (Faulkner, 2017). Burstow and LeFrançois (2014) argue that resistance to psychiatry may be as old as the institution of psychiatry and its violent tendencies have been exposed by various Mad scholars through radical and critical points of views.

Diamond (2013) proposes that there are ways to bring forth understanding and empathy by understanding that the language of mental illness or the medical model has major repercussions. Furthermore, she states it is important to understand intersectionality and madness, and the impact that privilege has in society’s political, cultural and social institutions that shape our organizations and programing, putting service users at risk of marginalization, discrimination and oppression (Diamond, 2013). Organized groups of consumer/survivors in Canada contend that society’s organizations must adjust to the needs of consumer/survivors, not the other way around (Starkman, 2013). Further societal adjustment and change is needed in Canada due to its current oppressive ideology of neoliberalism, a strong influencer of the medical model in mental health services.

Mental Health Paradigms in Canada

Ontario, like other provinces, employs a limiting definition of mental health that reflects the medical/pathology model, and has been criticized by some as too narrow to be effective. Strongly influencing mental health service delivery and social workers who work in mental health is the presence of the medical model in mental health services. The medical model is representative of neoliberalist values in Canada. As a way to reform the mental health system, mental health recovery was implemented in services, originally conceived of as a shift in dominant ideology. The concept has been implemented and established in mental health services to reflect neoliberalist values as opposed to psychiatric consumer/survivor values. The following section will outline the defining features of neoliberalism, the medical model, and recovery in mental health practice, resulting in two competing paradigms currently representing mental health services.

The Neoliberalist Paradigm and the Medical Model in Mental Health Services in Canada

The term neoliberalism can be defined as a market society, which values individualism and places human beings as responsible for their own well-being (Cosgrove & Karter, 2018). Despite the political, social, and economical issues that influence the lives of human beings, neoliberalism strongly values the destruction of social policy, placing the burden on individuals who deviate from social norms (Raphael, 2007). Neoliberalism as a dominant ideology has influenced the retrenchment of the social welfare system in Canada (Mullaly, 2007). This retrenchment stems from the standpoint of governments that social welfare is a way of minimizing individual initiative (Mullaly, 2007). Those who rely on the welfare state are then at risk for being associated with pathology as they can be considered dysfunctional or irrational (Cosgrove & Karter, 2018). This definition of normalcy is too narrow, as it ignores the

economic, social, and cultural aspects that impact users of mental health services, as pathologies that are formed are largely separated from social issues. Social service spending is then viewed as both unnecessary and as intrusive to the individual (Mullaly, 2007). This argument brought forth by Mullaly (2007) refers to the focus on individual deficit. Moncrieff (2008) argues that this is a form of social control, contributing to social injustice and inequality. This is visible in mental health service delivery today due to certain treatment approaches rooted in the medical model. For example, the use of diagnostics and medication could be considered a form of social control, as those who deviate from social norms can be coerced into treating madness, ignoring the strong social factors at play.

Those who are regarded as mentally ill are especially vulnerable in a neoliberalist society, as some may be unable to access employment, housing, and basic human rights, but are solely responsible for their own well-being under a neoliberalist paradigm. What is defined as productive or desirable puts marginalized groups at a disadvantage and individual shortfalls become a valued explanation for deviance from social norms (Esposito & Perez, 2014). Using a biomedical lens in understanding human behaviour continues to place the burden on individuals, as the expectation of self-reliance diminishes social bonds and makes space for structural violence (Esposito & Perez, 2014).

Social control stems from a number of powerful sources, such as social policy, law, medicine, and education. Understanding how neoliberalism influences how Canadian citizens understand madness can be seen in multiple legal acts and frameworks. For example, White and Pike (2013) refer to The Mental Health Act of Ontario (OMHA, 1990), defining ‘mental disorder’ as “any disease or disability of the mind” as quoted by White and Pike (2013, p. 243).

White and Pike (2013) argue that this definition of mental disorder is under referenced and does not include social contributions to madness. Another example of how mental illness is defined in Canada is reflected in the Government of Canada's report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (White & Pike, 2013). This report intended to address issues in the mental health system and to make recommendations on service delivery, but instead reflects the medical model (White & Pike, 2013). The way madness is defined through pathologizing language refers to madness as a disease. Neoliberalist values can be seen in these definitions and are further developed through government initiatives, such as the Mental Health Commission of Canada (MHCC). The MHCC (2020) created a mental health strategy in Canada called, *Changing Directions, Changing Lives,* in 2012, outlining the need to reform the mental health system toward recovery. The MHCC (2020) and defines recovery as:

> The concept of 'recovery' in mental health refers to living a satisfying, hopeful, and contributing life, even when a person may be experiencing ongoing symptoms of a mental health problem or illness. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments…...Championed by people with lived experience of mental health problems and illnesses for decades, recovery is being widely embraced by practitioners, service providers, and policy makers in Canada and around the world. It is recognized as key to achieving better mental health outcomes and improving mental health systems. (p. 1)

Although the definition of recovery provided by the Mental Health Commission of Canada suggests a service user's right to self-determination, the definition is contradictory to the true

values of recovery due to the pathologizing, symptomatic, medical model language. Mental health recovery initially intended to shift mental health services toward a less medical approach evident in many of the leading legislations above. Recovery has since been formulated into a model as opposed to a paradigm shift originally conceived of by consumer/survivors (White & Pike, 2013). The origin of mental health recovery, perspectives from psychiatric consumer/survivors as outlined in various literary resources and how recovery fits into current practice as a competing paradigm to the medical model will be explored in the following section.

The Recovery Paradigm in Mental Health Services in Canada

Mental health recovery in Canada originated from the psychiatric consumer/survivor movement and was conceptualized as a resistance to the superiority of psychiatry (De Ruysscher et al., 2019; Morrow & Weisser, 2012; Onken et al., 2007; Piatt & Sabetti, 2011). The concept of recovery has shifted in recent years, and Nelson (2012) states that recovery orientation in mental health service delivery in Canada is associated with two competing paradigms, one can be defined as biomedicine, which dominates, and the other is recovery. Recovery as a paradigm shift originated from the psychiatric consumer/survivor movement with origins in the ex-patient liberation movement in Canada in the 1960s and 1970s and has been implemented in mental health services in a way that reflects biomedicine and neoliberalism (Morrow, 2013; Morrow & Weisser, 2012). Due to the gap between its origins and how it is now delivered in mental health services, the concept of recovery has been corrupted (Morrow & Weisser, 2012). As recovery is often associated with the idea that there is a goal to be reached, it often reflects the medical model and personal change, as opposed to broader social change (Morrow, 2013). Poole (2011) illustrates mental health recovery as “white and credentialed” as it represents individual deficit (p. 87).

Nelson (2012) argues that the root of the recovery paradigm was to shift power and control within mental health practice and policy. The concept of recovery was implemented to fit into existing mental health services and has been formulated into a model as opposed to a paradigm shift originally conceived of by consumer/survivors (White & Pike, 2013). The defining features of this intended paradigm shift can be further understood through exploration of the concept itself as it is conceived of by psychiatric consumer/survivors.

Defining Mental Health Recovery

There is some lack of consensus in the literature reviewed as to the meaning of recovery as to whether people understand it as a movement, a model, an approach, or as a paradigm shift. The definition of mental health recovery throughout the literary sources reviewed is inconsistent, presumably due to the way recovery has been implemented in mental health services as a model instead of a paradigm shift and is overshadowed by the medical model. As this advanced practicum project respects the lived experiences of consumer/survivors and Mad activists, recovery will continue to be referred to as a paradigm shift, as this was the original vision of recovery; as a resistance to the dominance of the medical model.

Morrow (2013) stresses the importance of looking at recovery from a neoliberal, capitalist perspective. Often discounted from mental health recovery is the social, political, economic and cultural considerations which impact individuals. The individualist component of what is defined as mental health recovery is a limitation in itself, as it does not consider broader structural oppression (Morrow, 2013). Morrow (2013) reflects on recovery from a political perspective and contends that recovery was originally an attempt at a paradigm shift, but there are now various considerations of recovery due to medical discourse in mental health service influence. As suggested above, these considerations include recovery as an approach or as a

model. Rooted in the psychiatric consumer/survivor movement, recovery was conceptualized as a fight against the medicalization of mental health and the power of medical professionals, such as psychiatrists, while professionals in the mental health field have used this approach for the needs they have observed among consumers (Landry, 2017; Morrow, 2013).

Slade (2009) conceptualizes recovery through two definitions: 'clinical' recovery and 'personal' recovery. Personal recovery is considered a consumer-based point of view, which is often considered a 'journey', as opposed to clinical recovery, where 'getting rid' of problems and symptom management come first (Slade, 2009). Adame and Knudson (2008) highlight the link between the personal and political through lived experience of four psychiatric consumer/survivors. They use the concept of 'the empty self,' defined as a form of self that is bounded to individualistic views and in the absence of community and shared meaning among lived experiences of 'mental illness' (Adame & Knudson, 2008). Mental health services have demoted the meaning of recovery through the use of the medical model to make sense of these lived experiences. Medical model terminology and practice influences societal knowledge on madness without consideration of the political, social and economic implications on various individuals and groups in society (Adame & Knudson, 2008).

Adame and Knudson (2008) support Hyden's (1995) view that recovery can be considered a person's narrative life meaning, and is tied to the social contexts of self, as well as personal self-image and aspirations in life. Recovery in this sense, can then be viewed as a relationship and conversation between 'therapist' and 'client' on the meaning of 'a good life' (Adame & Knudson, 2008). Using 'the good life narrative' shifts the focus from individual deficit and aims it toward the individual's social location in the world and systems of oppression (Adame & Knudson, 2008).

Deegan (2002) writes about her lived experience with recovery. Deegan (2003) defines recovery as a process that is transformative and self-directed in finding one's new sense of self. She describes the exploration of her identity following a diagnosis of schizophrenia, and reveals what pathologizing can do to one's self perception. Deegan (2002) concluded that she began to internalize the stigma she received from others around her 'mental illness', and overcoming this was challenging due to social norms and expectations (Deegan, 2002). This example represents how dangerous labelling and treating madness can be, especially with the coercion and influence of mental health professionals. Deegan (2002) argues that recovery is about self-directing, not being compliant, as the transformative process for recovery should be credited to the individual. Deegan (2002) further contends that in order to understand what recovery means to someone, professionals in mental health must understand what resources and gifts each individual has to offer. As Deegan (2002) states:

> People are more than their diagnoses. People diagnosed with mental illness are resilient and are more than passive victims of disease processes. Professionals who learn to collaborate with the active, resilient, adaptive self of the client will find themselves collaborating in new and rewarding ways with people who may have been viewed as hopeless by others who reify diagnoses and related prophecies of doom. (p.19)

Adame and Knudson (2008) review recovery research and the various meanings that have emerged throughout the literature. These definitions reflect different perceptions and ideas about recovery. An example of these uncovered meanings of recovery includes acceptance of differing experiences, instead of striving for normality as imposed through social norms (Adame & Knudson, 2008). Another form of recovery can be retelling a life story to create new meanings and a richer narrative (Adame & Knudson, 2008). This can be done through narrative

construction or deconstruction in order to make meanings and define one's life (Adame & Knudson, 2008). Adame and Knudson (2008) further argue that individuals are not freestanding from their social worlds they live in.

Morrow (2013) argues that using the recovery approach currently used in mental health services, puts consumer/survivors at risk for experiencing oppression. This can result in experiencing sanism, which may be intentionally or unintentionally reinforced by mental health workers. Experiences of mental distress with links to sexism, racism, or sanism are the driving forces of Mad studies and the psychiatric consumer/survivor movement. Participants in "recovery talk" research in British Columbia brought forth various themes within recovery, such as peer support, a social justice approach, and language surrounding recovery (Morrow, 2013). Morrow (2013) suggests that continuing the conversation of recovery is important, as recovery is currently a changing ideology toward madness. Morrow and Weisser (2012) argued that policy makers and mental health practitioners must address recovery. Challenges that come with this push is that there are many rejections of recovery due to sanism and the medicalization of mental illness (Morrow, 2013). Price-Robertson et al. (2017) argue that recovery has "gone mainstream" since it's derivation from the psychiatric consumer/survivor movement and has since been adopted by mental health agencies and practitioners due to the goal of mental health system reformation from the MHCC.

Price-Robertson et al., (2017) argue further that mental health professionals and policy makers have diminished the true meaning of recovery and social justice by orienting recovery discourse with the medical model. The professionalization of recovery then, is defined by mental health workers, failing to address the core values of this paradigm due to the dominance of the medical model (Ruysscher et al., 2019). Social workers are among these mental health

professionals who deliver mental health services in Canada and are highly impacted by these competing paradigms of the medical model and recovery. Many social workers do not recognize how they are influenced by the medical model, or it is taken for granted.

Recovery Practice-Social Work Practice

Social workers are in a position to work against injustice experienced by individuals and groups in society and have a professional and ethical responsibility to do so. As per Canadian Association of Social Workers (CASW) standards, social workers belong to a community dedicated to achieving social justice and the welfare of all people (CASW, 2005). Social workers who work in the mental health sector face many challenges as they hold responsibility to practice anti-oppression and self-control over their personal beliefs, which can contribute to oppression in the form of sanism. This is challenging working under the constraints of macro level policies and institutions by which social workers are employed (Breslow, 2019). McKeown et al. (2014) argue that front-line workers in mental health services are often the ones who receive critiques of care from consumer/survivors. The following section will elaborate on the implications of social work practice as it relates to the mental health field and will explore possible useful interventions to respect the lives of consumer/survivors within the limitations of the mental health system.

Joseph (2013) argues that the field of social work has moved away from its original values of social change and helping vulnerable groups, especially in the field of mental health. This is due to treatment-based mental health practice as a reflection of the medical model and psychiatric treatment (Joseph, 2013; Poole et al., 2012). Slade (2009) explores recovery within mental health service delivery by defining the primary purpose, goals, and values and argues that the core values of mental health services must change in order to advocate for consumer/survivors. Slade (2009) argues that there may be a discomfort for service users

working with mental health practitioners who do not have lived experience (Slade, 2009). Shimrat (2013) suggests that social workers could simply ask the question, “what can we do to help you?” instead of assuming the needs and answers of service users, which is an approach useful in all areas of social work in order to resist oppression. This is again linked to broader social concerns, in that power systems that exist in the form of structural oppression need to be altered in order for real change to occur. McKeown et al. (2014) states, “we believe there is great potential for personal and wider social change, as well as reciprocal benefit, from both formal and informal alliance-formation” (p. 146).

Social workers are at risk of sanist attitudes if they are guided by pathology, diagnosis and interventions (Poole et al., 2012). Joseph (2013) argues that true social work values are more consistent with psychiatric consumer/survivors as opposed to the medical model, creating a major contradiction within the current mental health sector for social workers. For social workers, changing their services to a recovery focus involves a shift in practice into a more collaborative role, which seems to be more consistent with core social work values such as promoting self-determination (Petros & Solomon, 2019). Furthermore, recovery is then the first priority as opposed to symptom management, which can involve coercion for service users to medicate, as opposed to recovery principles, such as mutual learning and collaboration (Petros & Solomon, 2019). This alliance is important in beginning to challenge sanism and other forms of oppression, which can begin with recognizing a person beyond their diagnosis and prioritizing or privileging lived experience before one’s own expertise.

AOP and Anti-Sanism

Robbins (2011) breaks down anti-oppression theory into various categories, such as class, race, gender, sexual orientation and disability. Historically, anti-oppression theory relates to

social justice, in that all people should have the same rights and should expect equitable treatment, and overall equality (Robbins, 2011). This theory can be traced back to the early 20th century, where social workers were involved in social policy to improve conditions of vulnerable populations (Robbins, 2011). In the 1960s there was a renewed interest in the lives of those impacted by structural inequalities, and the social work movement of the 1970s, with a focus on poverty reduction and inequality, which influenced social policy (Robbins, 2011).

Structural social work was a key factor in developing the anti-oppressive standpoint. In oppression theory, there is a group that is oppressed, and an oppressor that benefits (Robbins, 2011). There must be a power difference in relation to this oppression, and a certain degree of disagreement (Robbins, 2011). This is structurally embedded in our policies and practices, reinforcing discrimination, marginalization and exploitation of vulnerable populations (Robbins, 2011). The opposite side of oppression is privilege and is considered an advantage that can dominate the "powerless" (Robbins, 2011). Using anti-oppression in practice is important when considering power dynamics within community mental health care and in one-to-one interactions.

Valued within anti-oppressive practice is social justice, including forms of injustice that exist within social work practice (Larson, 2008). Larson (2008) argues that critical self-reflection is necessary to recognize one's social location and one's influence on oppression. Through critical self-reflection, a social worker can understand on a deeper level how they contribute to oppression on the basis of sanism, among other oppressions such as sexism and racism. Larson (2008) contends that it is not enough to recognize these oppressions, a social worker must fight against these systems of oppression instead of standing within these injustices. Larson (2008) quoting Desai (2003) describes: "when it comes to intervention, social workers commonly feel

overwhelmed and debilitated by medical practitioners who claim much more expertise on mental health issues" (p. 42). This is reflective of the dominance of the medical model and the power dynamics that flourish under a state of neoliberalism. Larson (2008) argues that there is limited research to back up the medical model as it does not sustain 'recovery' and does not put the social environmental factors of an individual first.

Larson (2008) reviews multiple principles and approaches that can be used in practice for practitioners. He notes that identifying the obstacles faced by mental health workers is important. Larson (2008) explains that the first shift that is needed is to place the power back in the service users control, and in order to do this, an invitation to fully participate in services with the inclusion of family members is important, access to personal health information and including service users in meetings, policy development, and education. Larson (2008) argues that social justice in practice is difficult due to organizational and structural constraints. Regardless of this, Larson (2008) suggests partnering with service users, not just exploring the issue of injustice, and direct this partnership toward social action. Larson (2008) argues that these aspects highlighted above are valued within anti-oppressive practice and requires critical self-reflection and organizational reflection. Furthermore, Larson (2008) challenges medical model language that is used within mental health services. Using this language further oppresses service users but can be used to resist oppression. For example, addressing a service user by their name or the way they choose to be addressed, as opposed to using the term 'client.'

Luchies (2014) discusses the emergence of anti-oppression theory from the radical movements of feminism, anti-racism and queer, challenging the status quo and capitalism. He challenges oppression theory in that the problem with the theory is that it is a "political project" that focuses on developing practice, rather than theory, contrasting with the grassroots

movements it derived from (Luchies, 2014). He concludes that the language surrounding oppression is a struggle for North America, as it can restrict our analyses of power and he suggests it can reproduce white and male centrism and fail to capture the raw reality of oppression (Luchies, 2014). Furthermore, Larson (2008) argues that continued dependence on the medical model is common for social workers working in mental health due to reliance on assessment and diagnoses implemented in practice (Larson, 2008). Due to this reliance on the medical model in practice, anti-oppressive practice may be difficult to carry out within these settings (Larson, 2008).

Adame and Knudson (2008) argue that the role of a psychotherapist is to collaborate with a service user to explore their meaning of 'a good life'. The focus of the therapeutic relationship then should not be surrounding a fixed goal or treatment (Adame & Knudson, 2008). Even with a focus on the good life, there will be hardships to come as a part of every single person's life. Regardless of this, feelings of anger or sadness may be utilized in a way of addressing systems of oppression and those who labeled them as ill, sick, deviant or insane (Adame & Knudson, 2008). This lessens the burden on the individual, for them to be less angry with themselves, and angrier with the world around them. Medicalizing and individualizing keep individuals away from focusing on their strengths (Adame & Knudson, 2008).

Morrow and Weisser (2012) discuss anti-oppressive practice (AOP) and suggest that it may hold some promise for recovery as a paradigm shift and in light of consumer/survivor perspectives. They argue that these approaches have partially been implemented in the mental health system, however, sanist attitudes and systemic barriers make it difficult to practice true AOP (Morrow & Weisser, 2012). What is missing from AOP is the concept of sanism as a deeply rooted form of oppression as many people are at risk of holding sanist attitudes. When

looking at oppression, we must look at the structural inequalities that exist. As Everett (2000) states, “mental health reform, in the present incarnation, could not possibly work because power dynamics haven’t changed” (p. 209).

Morrow and Weisser (2012) explored various themes that emerged from their World Cafe methodology, where participants discussed intersectional issues in mental health in Canada. What emerged from this study were certain areas that needed to be addressed in mental health (Morrow & Weisser, 2012). For example, participants concluded that addressing power and control from mental health practitioners and their mandates as vital to recovery (Morrow & Weisser, 2012). Furthermore, they discuss the difficulty with hiring peer support workers at a mental health agency governed by medicalization of mental illness (Morrow & Weisser, 2012). The participants state that they were expected to be professional and act ‘normal’, in order to reflect social norms, and practice the values of the medical model (Morrow & Weisser, 2012).

Morrow and Weisser (2012) ask, “what would it take to transform the mental health care system and does recovery have a role in this transformation?” (p.39). They answer this through the perspectives of participants. First, understanding that sanism is critical for understanding mental distress, as well as linking this back to systemic oppression with its intersections with sexism, racism, ageism, classism and heterosexism (Morrow & Weisser, 2012). Furthermore, they state that psychiatric consumer/survivors must lead recovery as they originally envisioned it, as well as incorporate peer support as originally envisioned (Morrow & Weisser, 2012). Currently, the implementation of peer support in mental health service agencies is through employment of peer support workers in the mental health system (Slade et al., 2017). With this employment, consumer/survivors in community mental health agencies do not have the opportunity to lead the revolution of recovery as they envisioned it, but rather, how their

employer directs them through policy and procedure implementation, often guided by the dominant medical model. Lastly, they suggest addressing both the medical needs and the social needs of people through changing the social welfare system and opening the discussion of other understandings for ‘mental illness’ (Morrow & Weisser, 2012). With consumer/survivor knowledge, traditional power relations must be challenged with the support of the psychiatric consumer/survivor movement. Recovery as a paradigm shift is simply from ‘objective knowledge’ to ‘subjective experience,’ and that the medical lens is not the only way to view madness (Rudnick, 2012).

There is limited literature in connecting AOP to the psychiatric consumer/survivor movement specifically, as well as the Mad movement. There is, however, literature that critiques the medical model with suggestions for practicing true AOP. Larson’s (2008) review of anti-oppressive practice in mental health highlights the need for deconstruction of the medical model in order to implement true anti-oppressive social work practice. The medical model is a way of social control, and social workers often contribute to it by using pathology to define service users, all while taking away the power of the individual (Larson, 2008; Joseph, 2013). Larson (2008) argues that in order for a social worker to practice anti-oppression, they must part ways with the medical model, with a focus on structural social work. Poole et al. (2012) explore AOP as it relates to sanism and argue that collaboration and allyship are paramount to promoting social justice. This argument can help guide social workers working to develop their AOP through recognizing and challenging their sanist attitudes. Poole et al., (2012) do extend their argument on sanism in mentioning the Mad population in the way they have been pathologized and need to be treated due to sanist and oppressive attitudes.

Breslow (2019) explores the concept of sanism and various ways of developing an anti-sanist approach, which involves an understanding of sanism and how it can be deeply rooted in helping professionals, first by understanding the origin of Mad Studies. Second, it is important to recognize the role that professionals have in the medicalization of madness (Breslow, 2019). Third, service professionals should understand the policies within their institution and help to remove barriers (Breslow, 2019). Fourth, he suggests that using a medical model only disregards other contributions to emotional distress, such as oppression (Breslow, 2019.) Fifth, Breslow (2019) suggests learning about new ways to view 'mental illness,' possibly through less clinical approaches, such as the use of yoga or meditation as these are less western medical models. Lastly, Breslow (2019) points out the importance for professionals to understand their personal and work-related practice of sanism.

Perlin (1992) argues that the perspectives and experiences of consumer/survivors must be integrated into social work knowledge and practice, and they need to be included in the conversations that are directly impacting their lives. Ways that social workers can integrate this knowledge is through involving themselves in social action and promote social justice by partnering with service users regarding the injustices they face. This starts with exploring these injustices while also taking a stand on the human rights of those who use mental health services (Larson, 2008). Advocacy can be done by partnering with and making room for the voices of consumer/survivor initiatives at service or policy levels (Larson, 2008). An intervention that values this collaboration and partnering with service users is narrative therapy, as it is an approach that respects lived experiences through mutual learning.

Practice Intervention: Narrative Therapy

Narrative therapy is considered to be a non-blaming, a non-pathologizing and collaborative approach (Buckman & Buckman, 2016). Using a narrative approach may involve the use of values such as mutual learning and reciprocity with respect to the client's social context in which they live through deconstruction of recovery as contextualized by mental health services. Narrative approaches may offer some promise in terms of working from a recovery paradigm because it can help service users redefine their diagnoses or disregard them completely by creating new meanings. Buckman and Buckman (2016) explore the roots of narrative therapy, and discuss its specific forms of intervention, guided by clients exploring the meaning of their lives. An individual's narrative can define their own recovery, through narrative construction and deconstruction (Adame & Knudson, 2008). The definition of 'a good life' may be influenced by cultural and social expectations, which is where oppression and the social context of someone's life is of utmost importance, as well as in challenging sanism.

White (2002) reflects on his narrative practice and relationships with people who have 'consulted' him regarding various aspects of their lives. He states, "these people populate many of the territories of my identity - I regard them to be fellow travelers, and they have made significant contribution to the cast of the characters of my life" (p. 45). What is notable here is that Michael White identifies 'clients' or 'service users' simply as people who consult with him. Furthermore, he identifies people who consult with him as his 'fellow travelers', which assumes that he sees them as his equals. Another notable comment in White's statement is that he views the people who consult with him as significant contributors to his story of his life, which suggests that he, himself, is learning from them. White's insights offer practitioners guidance in

analyzing sanism and our sanist attitudes, as they can serve as a reminder that we are all human beings on a journey, both together, and separately to understand their lives. As White notes:

> The therapeutic context provides an opportunity for the people who consult therapists to become not other than who they are, but to become 'more truly who they really are' - to gain access to a life that is more accurate expression of what it is that is considered to be 'human nature'. (p.49)

White (2002) argues that narrative practices are related to traditional practices and understandings of life, specifically folk psychology. He contends, "folk psychology… it is distinguished by the notion of 'personal agency'. It casts people as active mediators, negotiators and as representatives of their own lives, doing so separately and in unison with others" (p. 67).

Rudnick (2012) argues that narrative theory and recovery are together two emerging themes in consumer empowerment. First, the recovery movement is about changing the political and social views of difference (Rudnick, 2012). Second, narrative theory down to its roots is listening to stories and helping individuals on a clinical level organize, select and shape the facts that matter most to them (Rudnick, 2012). Rudnick (2012) reports that narrative therapy involves the re-authoring of one's story, as an individual often comes forward for clinical support due to some problem or concern. With a narrative approach of re-authoring, a new understanding of past and future can emerge and move toward recovery with this new story, thus providing 'service user control' as opposed to expert knowledge of the clinician (Rudnick, 2012).

White (2004) refers to modern power and when this is considered in therapeutic contexts, it exposes those powers that oppress and highlights problems presented to clinicians that are a result of these operations of power (White, 2004). With re-authoring, these presenting problems and the impact of power can be both exposed and altered. Few resources refer to the recovery

paradigm and narrative therapy, however, sources such as Llewellyn-Beardsley (2019) refer to recovery narratives as a defining way to re-story consumer/survivor experiences, which could possibly fit with narrative therapy. The values that White (2004) promoted through his use of narrative therapy are important to note in this regard, due to his references to dominant power and the impact of this on therapy, shifting the person away from the problem and placing this into society.

In conclusion, much of the literature in this review refers to sanism in relation to the medical model as a result of neoliberalism and structural oppression, as well as a need for a paradigm shift in the Canadian context. The anti-psychiatry movement, psychiatric consumer/survivor movement and the Mad movement are interconnected through common goals and strategies in challenging current mental health services and the dominating medical model approach. These social movements fit into the larger psychiatric consumer/survivor movement, made up of those consumer/survivors, Mad, and anti-psychiatry activists directly impacted by mental health services. A review of the literature on the impact oppression has on consumer/survivors suggests that challenging structural oppression and sanism through a collaboration with service users, possibly through the use of narrative therapy, will help to work toward a recovery paradigm as envisioned by consumer/survivors.

Chapter 3: Reflection on the Advanced Practicum Experience

The roots of anti-psychiatry, the psychiatric consumer/survivor movement and the Mad movement have created a strong case against using the medical model as the only way to intervene and understand madness. There are strong tensions between current and dominating mental health service values and these social movements explored in the above literature. This dispute against medical model dominance poses major challenges for mental health service delivery in Canada, as social workers who work in mental health are often restricted in their practice due to program and policy mandates. As the mental health sector is guided by neoliberalist values, service delivery reflects the powerful dominance of medical model approaches. This is especially true in northern Ontario service users experience a lack of resources, and are therefore oppressed further.

The mental health sector has conceptualized recovery in a way that mirrors individualism as a value of the medical model, and has moved away from the origins of recovery, which aimed to battle oppression and dominating medical discourse (Morrow, 2013). Social workers working in mental health have the power to advocate for social change for those who have faced great disparity at the hands of the mental health system (Joseph, 2013; Petros & Solomon, 2019). Social workers can educate themselves on how to practice anti-oppression beyond what they are taught in school through critical self-reflection of their own social location, seeking out critical perspectives such as those offered by service user movements, and how they may contribute to oppression in the form of sanism.

Chapter 3 of the thesis report provides an overview of the practicum experience as it pertains to the achievement of my learning goals and questions. Here I reflect on my learning journey and connect my practice learning to theory, namely structural social work and anti-

oppressive social work practice, and the impact of neoliberalism and the medical model on service users and social workers. The reflection chapter discusses experiences of critical self-reflection during the advanced practicum experience, as well as the integration of narrative therapy as a practice approach in light of learning about recovery and AOP. The chapter concludes with implications for AOP and structural social work practice from a recovery and anti-sanist perspective and reflecting the important contributions of Mad studies and the psychiatric consumer/survivor movement.

Overview of the Advanced Practicum

My learning goals for the advanced practicum evolved from my foundational questions as outlined in chapter 1 (see p. 6). In order to understand the roots and goals of the recovery paradigm, the psychiatric consumer/survivor movement, and the Mad movement, I needed to observe how these values fit into mental health practice in a northern setting in Ontario.

During the advanced practicum at the Parry Sound office, I explored the tension between the ongoing recovery paradigm and the medical model in community mental health and continued to question how one can stay true to the core values of the recovery paradigm when the medical model dominates community mental health practice. At the onset, I hypothesized that narrative therapy may hold some promise in respect to the recovery paradigm and could be used as an intervention in both CT and EIP, separate from dominating approaches at CMHAMPS, such as dialectical behaviour therapy and cognitive behaviour therapy most often recommended by consulting psychiatrists. There is the expectation that practitioners at CMHA intervene with evidence-based practices, however, many practitioners have an eclectic approach and utilize multiple interventions to suit the needs of service users. Furthermore, CMHA employs workers of all different credentials such as social workers, registered psychotherapists,

nurses, addiction workers and social service workers. Due to this, all employees bring forth unique and diverse experience and approaches, which afforded me the opportunity to choose narrative therapy.

My objective was to learn more about narrative practice and utilize it in one-to-one sessions in CT with service users. I also employed mindfulness meditation, which became a tool I used both with service users in group and individual settings, with my supervisor and my team, and with myself. Mindfulness taught me to connect to my own biases and judgements, and thus, how I contribute to sanism as an oppression in the mental health sector. With this personal practice, I could see the benefit it could bring for service users should they wish to learn about mindfulness. This self-reflection then helped me initiate conversations about service users' oppressive experiences in the mental health system in northern Ontario, shifting the conversation from the person as the problem toward social issues and oppression in order to practice AOP and structural social work. Furthermore, I started to recognize sanist attitudes that influence decision making in the hospital and among my peers and achieved transparency with service users and staff about my own social location in acknowledging that I do not have the lived experience of madness, further helping me develop AOP.

Background

The inspiration behind this advanced practicum project developed during the first year of my employment as a crisis worker at CMHAMPS. I had witnessed sanist attitudes in physicians, psychologists, psychiatrists, managers, my peers and in practices, although at the time I was unable to define them as such. These sanist attitudes appeared in multiple forms, such as during the process of involuntary admissions to schedule one facilities and through psychiatric consultations, also reflective of structural oppression in the way it exists institutionally and in

policy. I began to recognize this deeply rooted oppression in policy and practice at CMHAMPS due to the criteria that service users at CMHAMPS must have a ‘serious mental illness.’ I witnessed how these policies and practices influenced workers and managers to coerce service users and determine the intervention and treatment for service users should they wish to ‘recover.’ It was the recognition of this form of oppression that led me to Mad studies, which contributed to my knowledge and deepened my understanding of sanism. I then considered how I could further my understanding and practice of AOP and structural social work with the influence of my own social location as it impacts service users.

The medical model treatment-based approaches I witnessed, engaged in, and carried out in my crisis position highlighted the problem I sought to resolve: the dominance of the medical model and oppressive approaches that are embedded in the guiding principles of community mental health. For example, the referrals to each internal program are at times based solely on diagnosis or recommended treatment from psychiatry. I let this problem guide me to help develop the advanced practicum project learning goals and foundational questions. The advanced practicum was then carried out in isolation from my role as an employed crisis worker as I used the opportunity to explore these issues and enhance my intervention skills. As I do not provide any other intervention aside from crisis intervention and intake in my role as a crisis-intake worker, I was able to enhance my counselling intervention skills in CT through 8-12 sessions with each service user. I chose to expand my knowledge on the anti-psychiatry, psychiatric consumer/survivor, and Mad movement due to the connection these movements have to the recovery paradigm. From this, I was able to apply my knowledge to practice as I furthered my understanding of AOP and structural social work practice, as these movements all connect in the

way they challenge the dominance of the medical model and societal oppression, influencing the need for a paradigm shift.

The initial recognition of sanism led me toward exploring the concept of recovery. As CMHAMPS (2018) mission statement is, “Canadian Mental Health Association, Muskoka-Parry Sound Branch is committed to hope and recovery through integrated mental health and addiction services” (p. 1), I realized early on in my employment that I truly did not know the meaning of recovery. I questioned how this concept is conceptualized and applied at CMHA, and chose AOP, structural social work practice, Mad studies and the psychiatric consumer/survivor movement to help guide my learning during the advanced practicum. I had the opportunity to choose evidence-based interventions that I wanted to learn more about and apply them to practice in relation to my learning goals. This opportunity was presented to me as clinicians at CMHAMPS choose their own therapeutic modality. With this, I chose two evidence-based practices, narrative therapy and mindfulness-based practice, as interventions that could support my learning about recovery as envisioned by psychiatric consumer/survivors. Narrative therapy would allow me to collaborate with service users in a way that respects their lived experiences, through listening to their personal narratives and storytelling, as well as explore their oppressive experiences. Additionally, mindfulness would allow me to bring forth a more holistic approach different from common and popular modalities such as cognitive behaviour therapy, which in my experience, is an approach commonly used following diagnosis as treatment for anxiety or depression. In order to gain counselling experience, separate from crisis intervention, I initiated one-to-one sessions and facilitated a mindfulness group in CT. The mindfulness group surfaced my own judgements, as well as furthered my skills on group facilitation and dynamics of a group. The one-to-one sessions helped me surface oppressive experiences by the use of

interventions in narrative therapy, as I was enrolled in the narrative therapy certificate program at SickKids throughout the entirety of my practicum.

Supervision

In EIP, I had the opportunity to listen to the personal narratives of lived experience in sessions, and conversations about the meaning of recovery took place in supervision. Formal supervision took place biweekly with my supervisor, Kathy Harris. Informal supervision was approximately 1-2 times per week as Kathy and I shared cases and debriefed at any opportunity. Typically, formal supervision provided both Kathy and I the space to bring forth questions and review my caseload, as well as interventions I was utilizing in session. Kathy monitored my documentation and provided feedback. Occasionally, Kathy and I sat down and discussed both of our approaches to therapy, and how she engages with service users in the EIP program.

When I was first introduced to Kathy Harris in a team meeting, the first thing I noticed was her case formulation, treatment planning, and terminology. While team meetings involve a strong use of medical terminology and are highly clinical, it was known to colleagues that Kathy does not use diagnostics and medical language when referring to the service users in her program. In fact, she did not use diagnoses at all and refused to use terminology in the DSM, such as “bipolar” or “schizophrenia.” When I asked Kathy about this, she simply told me that she felt that these terms are pathologizing and unhelpful, so she refrains from using them. Kathy does recognize that eligibility for programming depends on diagnostics, however, once in service, Kathy refrains from using the terminology unless absolutely necessary. With the topics of interest in the advanced practicum, I felt this initial understanding of Kathy’s approach would fit well with what I was interested in learning about. As I continued to build my relationship with Kathy, I learned that her approach to therapy is much more holistic than I even thought possible

while working at a treatment-based community mental health setting. I learned that she utilizes equine therapy, arts, and mindfulness meditation. These approaches are unconventional compared to the frequent use of cognitive behaviour therapy or dialectical behaviour therapy. Kathy had stated to me during multiple meetings that her unique approaches, such as equine therapy, helped move service users in the EIP program toward "recovery" as it allowed service users to express and explore their experiences through something other than talk therapy.

Supervision with Kathy not only consisted of what I have outlined above, but also considered structural and policy issues that exist at CMHAMPS that directly impact our programming and services. I recall discussing an issue related to hierarchy at the agency in supervision that I had faced. Kathy and I engaged in a conversation about how difficult it can be to be client-centered when front line workers are directed by supervisors and managers. We explored various examples, and there is one I would like to bring to light to reflect how strongly influenced the mental health sector is by the medical model and neoliberalism. A service user who I had been working with was placed on a form 1 at the hospital. I was informed by another worker that this was due to the service user being unable to care for themselves due to "psychotic features." I was told in my team meeting by management that I must close this service user file as this individual had been transferred to a schedule one facility (i.e. Waypoint). From the viewpoint of CMHA policy, this transfer to Waypoint was considered a "transfer of care," although this service user was planning to continue service upon their discharge as part of their programming. I suggested an alternative plan, such as provide outreach and visitation to the hospital, as closing the file would not support continuity of care when the service user returns for service, as they would have to go through the intake process again due to the closing of their file. With my suggestion, management took this into consideration and supported my claim that this

was not client-centered, and they made the exception that the case would remain open and that I could provide outreach. This led into a conversation with both the manager and Kathy that there are many policies in place that are not updated and that they don't reflect the work being done in the field, and we were informed by the manager that this is something they have been told by numerous team leads and workers. I learned that there are many situations I must approach with caution and sensitivity in respect for my employer, while also advocating with service users.

When I first discovered Mad studies in my research, the association of the anti-psychiatry movement was emphasized for me due to our affiliation with psychiatry at CMHAMPS. When this topic was brought to supervision, Kathy and I discussed the lack of resources in northern Ontario, how psychiatry is “all we have” to keep some of the service users out of harm's way by possibly taking medications and keeping them “stabilized” while receiving treatment from CMHA. This influenced many of my interventions as there were times where changing the outcome was impossible. For example, the influence of physicians in keeping someone safe from themselves or others overpowers any influence workers had. Furthermore, there were many situations where I had to refer a service user to psychiatry in order to connect them to income support so that they could receive a housing subsidy or ODSP. During these initial conversations about psychiatry, I already had felt defeated as I felt that these issues were much larger than us as workers, and even as an agency. It was at this point I recognized I could support the empowerment of service users, and start the conversation about oppression, and dedicate my time to working within the confines of the mental health system, where the effects of neoliberalism are strongest at play against service users.

Kathy was supportive of my learning goals and engaged in multiple conversations about the meaning of recovery. These conversations were highly valuable for my learning experience.

The complexity of this topic initiated conversations about what it means to be a social worker in the community mental health sector. Kathy and I explored CASW social work standards and our ethical duty to practice anti-oppression. Here I learned that these structural issues are so deeply embedded in our practices, that there are often times where we use oppressive approaches without identifying them as such. We explored how strongly influenced social workers at our agency are by the medical model that we tend to lose sight of the societal impact on madness, and therefore contradict the goal of practicing AOP. The strongest part of my learning throughout supervision was to self-reflect before and after each interaction with service users. Kathy encouraged me to ask myself what my intentions and expectations were before each call and meeting I had with service users in order to understand if my intentions were self-serving, or truly for the goals of the service user. Kathy reminded me that this is important in order to minimize my expectations and personal goal setting for service users. I learned here how I could unintentionally oppress service users if they did not meet their goals, as they may feel responsibility for their distress, modeling individualism and the medical model. This learning experience was strongly connected to my social location in the way that I recognized how I can unintentionally oppress service users due to my working presence in community mental health. My social location sits within dominating culture and recognizing that was the most important part of this learning experience in order to begin challenging it by mutually collaborating with service users.

Reflection on Achievement of Learning Goals

My first two learning goals were research based and were further understood through the development of my literature review, with a focus on Mad studies and the many linkages to it,

including the antipsychiatry movement, the psychiatric consumer/survivor movement, and the Mad movement.

My third learning goal, to understand how recovery is conceptualized and applied in community mental health as exemplified by how CMHA applies mental health recovery as indicated in their mission statement. This was achieved through supervision, review of policies and procedures, and program delivery.

My fourth learning goal, to further my anti-oppressive social work practice by incorporating the knowledge and lived experiences of psychiatric consumer/survivors and the Mad movement, was achieved through critical self-reflection, counselling experiences both in 1:1 and in group settings, and the learning and practice of narrative therapy.

Recovery in Practice: Staying True to Principles of the Psychiatric Consumer/Survivor Movement

In order to further my understanding on the recovery movement present day and in northern Ontario, my third learning goal aimed to explore how recovery is conceptualized in mental health practice. As outlined in the methods section, I utilized research, supervision, reviewing of policies and procedures, and observing and engaging in program delivery. The first advanced practicum question reflects this learning goal: how can come stay true to ‘recovery’ as envisioned by psychiatric consumer/survivors and the Mad movement while working inside the mental health system in northern Ontario?

The literature on the mental health recovery paradigm as it is conceptualized in the mental health sector argues that neoliberalism continues to influence all policies and procedures in practice, even with the introduction of recovery. As with its origin, psychiatric consumer/survivors face what is now understood as the “recovery model” in mental health

services, which evolved from the intended paradigm shift from the medical model to recovery, and was then corrupted by neoliberalist values to fit into current mental health services (White & Pike, 2013). This is especially true in the mental health sector in northern Ontario, as resources are sparse, making it difficult to access progressive services for service users. As argued by CMHA (2018), the social and economic conditions in northern Ontario impact the health of citizens and cause greater health disparities as well as an increased need for mental health services. What services are provided are reflective of the medical model, and thus, there is limited consumer/survivor involvement in decision making as argued by Ryan-Nicholls & Haggarty (2007). Although there are a number of programs implemented in light of the psychiatric consumer/survivor movement, this does not go above peer support program employment nor does it challenge hierarchy in mental health agencies influenced by neoliberalism.

CMHAMPS appears to hold two competing paradigms, which appears to be a reflection of the influence of neoliberalism on the organization. As Nelson (2012) reports, recovery originated from the psychiatric consumer/survivor movement and the resistance to psychiatry. Therefore, it was difficult for me to initially understand where recovery fits into community mental health in northern Ontario. First and foremost, CMHAMPS utilizes many different practices, assessments and treatment options, mostly reflective of the medical model, with some exceptions such as the peer support program, namely the Council of Consumer/Survivor and Family Initiatives (C.O.I). The agency is partnered with all hospitals in the region, as well as with schedule one facilities in agreement that crisis workers can complete crisis assessments and recommend treatment plans for service users in crisis. Occasionally, this is in collaboration with family physicians or on-site psychiatrists consulting from Toronto. CMHAMPS uses psychiatry

to help guide treatment not only for medicinal purposes, but it is also for guidance on therapeutic interventions. This is a strong reflection of the medical model, opposite to the original goals of recovery to collaborate with service users on how to best provide services. Mental health recovery is a concept that has been gradually taken up by the community mental health service sector out of the hard work of psychiatric consumer/survivor activists and allies and is visible in different programs and practices, however it is a term I discovered is not commonly used by front-line workers at CMHAMPS. Currently, there exists the C.O.I. program at CMHAMPS, which runs the peer driver program, peer drop-in groups, and an employed peer sits on the panel during interviews for applicants to all programs in the agency. These peer programs are delivered by peer employees, who are guided by CMHAMPS policies and procedures like the rest of the staff. The peer staff do not give direction on policies, procedures, or programming nor become involved in decision making at that level, however they are involved with the interview process. Although peer workers sit on the hiring committee, the panel uses a scoring system based on standard questions.

How recovery has been formulated to reflect already existing mental health practices as opposed to a paradigm shift is visible in this outline of peer support at CMHAMPS, as peer workers, or consumer/survivors, are not involved in the decision making process and are limited in what power they do have in interviews due to the standardized scoring system. The continued overarching presence of neoliberalism has stationed the medical model in CMHAMPS policies and practices, contradicting the supposed paradigm shift toward recovery.

I engaged in conversations about mental health recovery with multiple social workers. For example, in supervision, Kathy and I discussed what recovery means in EIP. This came to light as Kathy and I had met with a service user who Kathy had identified as “in the recovery

stage." What Kathy reported she meant by this, was that the service user felt "stabilized" and the service user was ready to help others going through similar experiences. Furthermore, Kathy explained that the recovery stage for this service user meant that the individual was ready to move forward in discovery of themselves, and that it did not mean the goal was to return to who this person was prior to their "mental illness," but that they had the opportunity to grow in new direction if they wished.

Recently, the topic of recovery has been brought to light and discussed among working groups across programs at CMHAMPS. Management has asked that each program create a working group to review policies and procedures specific to each program, so that policies reflected the actual work being done in the field. As Breslow (2019) suggested that mental health professionals must understand the policies and procedures in their organization in order to influence change, I felt that this came at a pivotal time during my advanced practicum and during the research and writing for my thesis report. Many front-line workers expressed their excitement and interest in these working groups due to the rare opportunity that workers at CMHAMPS can influence decision making. Management encouraged us to start thinking differently from medical terminology and the DSM, i.e. severity of needs (severe, moderate, or mild mental health) and bring forth suggestions for change in policy and procedures that are progressive and reflective of recovery. Management stated that we will continue to use evidence-based and standardized scales and assessments, but that they are open to suggestions for change on things such as our intake screening, our terminology and determination of eligibility for services.

I stepped away from this meeting considering the concept of recovery and where the agency is headed. I was critical about formulating these working groups in that I questioned how it would be possible to use standardized, biomedical assessments, all while challenging medical

model language. I questioned, is it a true recovery approach if we only change our language, but not our assessments in practice? I wondered, what does this mean for us as workers, and how do we make suggestions for change without input from consumers/survivors for each program? These are questions I continue to ponder as I have now completed my practicum.

As part of one of these working groups, I have an opportunity to work as hard as I can to stay true to the recovery paradigm as I now have knowledge on the ideology as originally envisioned by consumer/survivors, and I have also now worked in three different programs in the agency with knowledge on how they operate. This is my opportunity to fight for real, even if minimal, change moving forward. A possible solution would be to engage with the peer workers at CMHAMPS and inquire with management about their involvement in each working group, as Perlin (1992) would suggest this is vital as services impact the lives of consumer/survivors.

A practice or intervention that I felt was strongly influenced by the recovery paradigm were the sessions Kathy and I had with EIP service users, which consisted of the telling and listening of lived experiences and personal narratives. Kathy and I created space for service users to reflect on their experiences and to tell their stories. Furthermore, other service users joined these sessions, which then formulated a group. What I noted throughout this intervention was that there was one common goal among all of the service users: they wanted to help others with similar experiences. Conversely, I question if creating this space with Kathy and I in it may have made service users feel less comfortable sharing their stories given our profession and risk of being “the experts” or the “professionals” in mental health. This was something we reflected on when we debriefed and tried to problem solve. What we concluded is that being as transparent as possible with service users about power imbalances may be beneficial, as well as expressing our

interest in mutual learning as a goal as opposed to us intervening in a way that reflects expert knowledge.

There were many positive things that came from these sessions, but most importantly, the mutual learning was highly valuable for me with the support of Kathy. I learned the difficulties that service users face while navigating the mental health system, such as involuntary admissions to a schedule one facility, being in chemical and physical restraints, being separated from their loved ones, not feeling heard by mental health workers or psychiatrists, and taking medications. I acknowledge that there were many advantages and positive outcomes from these sessions, namely that Kathy and I did not actually partake in any of them aside from observing and introducing service users to one another. This intervention was so powerful for me to witness, as it is very different from my employment as a crisis worker. Furthermore, this influenced my reflection on the impact of oppressive experiences and sanism.

How Sanism Influences Service Users and Social Workers

Sanism is a result of systemic oppression that has become normalized and practiced and is argued to be a result of the medical model by way of diagnosing, labelling and treating "mental illness" (Meerai et al., 2016). The invisibility of this oppression makes it dangerous to social workers and institutions who wish to practice AOP (Morrow & Weisser, 2012).

Prior to the advanced practicum, I witnessed and listened to various scenarios that resulted in painful and unjust outcomes, both in hospital settings and in one-to-one sessions where traumatic experiences were brought to light as a result of being involuntarily hospitalized. I did not put a name to this oppression that exists in the mental health system until my first year of my MSW, and this is where my journey into the research of Mad studies began. I wondered how I could practice AOP and incorporate this knowledge of Mad studies and the recovery movement gained

from research. From this learning goal, the second advanced practicum question was formulated: how does sanism impact my relationship with service users?

The most challenging part of the advanced practicum was reflecting on sanist attitudes embedded in myself, in my peers, in my agency, and in surrounding institutions. There were many points where I was highly critical of myself as a social worker as I recognized that my social location and my privilege in itself sustains systems of oppression. I felt that the power of capitalism was inescapable, and that my employment in a community mental health agency influenced by neoliberalism contributes to oppression. Although I learned about the impact neoliberalism and oppression has on Canadian citizens and mental health service delivery throughout my BSW, the recognition of this in the field taught me in a different way. I asked myself what I was going to do to fight against oppression without lived experience and with my own social location, and as argued by Larson (2008), critical self-reflection is essential to recognize privilege and understanding of oppression. I decided I would continue to collaborate with service users and learn how to develop an allyship with consumer/survivors that are currently in partnership with CMHAMPS in order to begin influencing the agency to involve consumer/survivors in decision-making beyond interviews and peer support groups. Furthermore, using narrative therapy will allow me to help service users make meaning of their own recovery, instead of influencing their decision-making.

I learned throughout the advanced practicum that sanism is visible almost everywhere at CMHA and in community partnership institutions, such as the hospital. I have observed it in the dialogue of professionals, in myself, in policies, and in clinical practices. There were various scenarios that I felt helpless due to my privilege and social location, as well as how this perpetuated power as a mental health worker. Perlin (1992) argues that mental health

practitioners are at risk of oppressing service users further, even if they intend to practice AOP. An example of this was when a service user attended the WPSHC and the staff there reported that the individual was experiencing psychosis. I was the worker who attended the hospital to complete the assessment, and I spent close to three hours creating a safety plan with this individual and their family members. This individual, I predicted, would not benefit if the doctor placed them on a form 1, due to the existence of a developmental delay, as well as past traumatic experiences in a schedule one facility. Although we achieved a strong safety plan and follow up, the emergency room doctor insisted on placing this individual on a form 1. I found myself in a position where I had to heavily advocate for this service user given both the circumstances and the relationship we had developed. I recognized that the individual had already placed their trust in me. In this situation, the physician held power over the service user and I and ignored the work that we had done together, and the individual was placed on a form 1. In this case, the doctor had expressed their fear that their license could be taken away due to the individual's risk of harming themselves due to their inability to care for themselves. In turn, the individual I was working with almost immediately lost their trust in me. With this loss of trust, the individual lost trust in the process, and refused support from CMHAMPS. I had difficulty coping with this due to these feelings of helplessness, and I brought it back to management. I was told this is the way things are, and that unfortunately, the decision of the physician is the final decision. I reflected on the power both the physician and I had in that situation and recognized that this individual was oppressed further and at the hands of the mental health system and that I was a part of this.

My own internal dialogue exemplifies my critical self-reflection that took place during the practicum in order to increase my self-awareness due to my own social location. I will explain the process and the outcome of my first interaction with a service user in EIP with an

example. The service user I started working with was willing to communicate with me only, and outside the walls of the agency away from other professionals. The foundation of this case was our therapeutic relationship, and that our discussions were completely separate from the topic of mental health. This was the first time I realized just how influenced I am by the medical model, as I often found myself wondering, “what is his diagnosis?”, “is he taking his medication?” and further questioning myself, “why do I feel the need to know what I’m ‘dealing with’?” or, “am I doing something wrong since they won’t open up?” I learned through supervision with Kathy that I needed to meet the service user where they were at and self-reflect on my internal dialogue and intention of each interaction. I did just this and began to change my approach.

Something I feel is notable here is that I met with this service user and we did not talk about mental health, we only talked about the service user’s hobbies, interests, movies and music. An intervention that I did use later in the relationship involved bringing service user letters written by another service user, exploring their experiences and the promise of hope and recovery. This specific example helped me reflect on my own judgements and oppressive approaches, and challenge them by changing my approach, as well as providing the service user a connection with someone other than myself that I would never be able to achieve, simply because I do not have lived experience. I felt, at this time, that I was practicing AOP as I was providing the service user with a unique opportunity, where we thought outside of the box from our regular practices and interventions. This was a reminder that the services we provide are about the service user, not about our expertise. I needed to hand over my “expert” cap and give the space to someone who understands madness and who has lived through it, to be a peer to this person, even if it was indirectly. This led to multiple discussions of the importance and value of what may be considered peer support with Kathy. We recognized and discussed that there is a

strong bond between those with lived experiences in the mental health system and that their experiences can be quite similar while living in northern Ontario. I acknowledge that I must learn from these experiences and challenge sanism by utilizing AOP, as well as utilize my own self-awareness to improve my practice in order to respect the lives of consumer/survivors and service users.

Resisting Sanism and Practicing AOP

Throughout the advanced practicum, I practiced mindfulness and began to recognize and acknowledge judgements and evidence of sanism. Breslow (2019) suggests that the use of mindfulness, or other less western approaches, are ways of viewing madness separate from the medical model. This proved to be complimentary of my learning of narrative therapy and AOP. I felt that this moved me away from the medical model, as Larson (2008) argues that stepping away from the medical model is essential to AOP. There were various circumstances during the advanced practicum where I surfaced oppressive experiences and shifted the conversation from individual deficit to the social, political and economic problems in northern Ontario in order to practice structural social work strongly advocated for by Larson (2008), thus beginning to explore interventions away from the medical model. Learning how to practice AOP while incorporating my knowledge on recovery movement as a learning goal also connects to my final question: how can a practitioner without lived experience of ‘madness’ facilitate anti-oppressive social work practice and resist sanism in the mental health system?

When I first entered the CT program, I initiated counselling sessions by building rapport and learning about what brought individuals into service at CMHAMPS. I initiated counselling with the first service user on my caseload in CT with complete transparency and from a decentered stance, stating that I was there to listen and privilege the service users' knowledge,

not my own. I had hoped this would help me stay true to recovery as originally envisioned by consumer/survivors, as suggested by Morrow and Weisser (2012), as well as working toward AOP. As sessions unfolded and moved forward, this particular service user was able to make connections, starting from whom and where they received various messages about who they are as an individual in society. For example, they concluded they felt unlovable, or that the abuse they endured was a fault of their own. From the support of narrative therapy training, we were able to link these messages to the institutions in society that informed these beliefs. In narrative therapy, this could be considered the service users 'outer judges.' We quickly learned together that this service user had internalized many of these messages received from various sources, and we named these institutions as patriarchy, marriage, sexism, and racism.

Reflections on Narrative therapy for Anti-Sanism, AOP and Structural Social Work Practice

During the practicum, I was able to use narrative interventions to explore these social institutions even further, and the effects they have made on the lives of service users. Moreover, I worked with service users to reframe life stories or identity conclusions, as well as privilege or bring to light alternative stories to shape the recovery experience in a way that respects the needs of the individual. One intervention in narrative therapy that I found extremely beneficial was to externalize problems. For example, we began calling depression 'the depression' or an eating disorder by a person's name, such as 'sally,' so as to move the problem away from the person. Another example is when the service user externalized depression and anxiety and named them as a child that appears in their life. This provided me with the opportunity to ask the service user, "how do you nurture the child?" or, "how do you take care of it?" or, "when is the child most active?"

By utilizing narrative therapy and mindfulness, I feel I am working towards my practice of AOP and anti-sanism. Within the narrative training, we had open floor discussions about socially constructed “shoulds” and the effects of these on society. This led me to ponder various ways of bringing this idea forth in session, such as asking, “when did you first learn that this is what you should do?” and, “who taught you this?” and, “what is required of you to meet these standards?” This often provided me with a clearer picture of where the service user developed these understandings and to recognize what the effects have been, such as these social requirements of these “shoulds,” resulting in depression or anxiety. These examples reflect how I believe I will be able to explore recovery as contextualized by the mental health sector and begin to deconstruct these ideas so that service users can define their own recovery process.

The critical self-reflection and increased self-awareness that took place during the advanced practicum experience was the first step in learning about how deeply rooted sanism is everywhere. Utilizing narrative therapy as a practice approach helped me expand my knowledge on how to collaborate with service users, achieve transparency due to the impact of my own social location in light of recovery, practicing AOP and structural social work and in challenging sanism. Creating an allyship with service users also begins to respect the lived experience of consumer/survivors.

Chapter Four: Conclusion and Implications for Social Work Practice

I have concluded that a possible way of exploring the tension between the medical model and mental health recovery in the mental health system is through mutual learning and the practice of anti-oppression. Social workers are taught to resist oppression in the institutions that surround and shape us. Acknowledging that social workers are at risk of oppressing service users while working in mental health is the first step in order to reform the mental health system. Workers in mental health must move away from expert knowledge and the medicalization of mental health by engaging with service users and their lived experience. Social workers can reflect on how they contribute to oppression by their own social location and use this to place the people they work with in relationship to their environment. As the literature suggests, partnership with consumers/survivors is vital to understanding the social and medical needs of this population (Larson, 2008; Slade, 2009). Furthermore, the literature suggests that narrative therapy compliments the original goals of the recovery paradigm (Llewellyn-Beardsley, 2019; Rudnick, 2012).

Social workers in mental health services have the opportunity to advocate for change. This can be done through gaining recovery knowledge by exploring the literature on the many topics available, such as the anti-psychiatry movement, the psychiatric consumer/survivor movement, the Mad movement and the recovery movement. Furthermore, social workers can explore power systems and hierarchy within their organizations and challenging oppression by practice of anti-sanism and AOP. Although much of the literature suggests that those without lived experience will likely not understand the experiences of those with lived experience of madness, I believe a partnership through mutual learning can begin to not only acknowledge this difference but use it as an advantage to fight for social change.

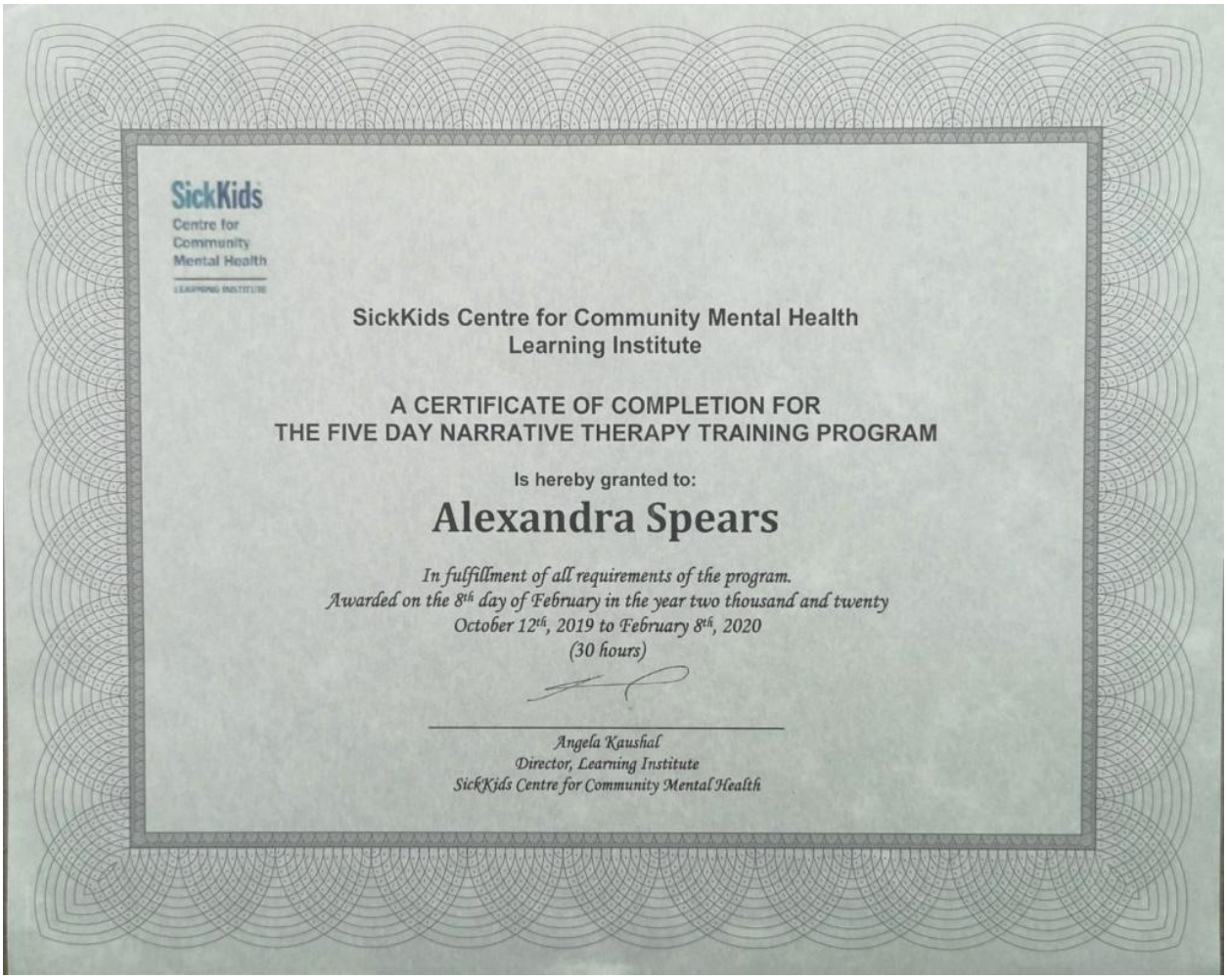
What I have recognized throughout my practicum is that advocating for social change must start now. As a social worker who works in the mental health sector, I can choose to advocate for social change on a micro level by engaging in conversations about oppression and how to fight against it. I must continue the conversation of recovery, as well as advocate for the involvement of consumer/survivors, possibly through partnership with consumer/survivor led initiatives, such as C.O.I., and ask for advice on how peer support needs to be implemented as they originally envisioned. Furthermore, I can begin challenging systemic oppression and barriers by influencing a change in policies and procedures through the opportunity of this working group. This may help CMHAMPS further their knowledge on madness, not just from a medical perspective, but through the social needs identified by service users. If the mental health sector were to move toward a true recovery approach, consumers/survivors who have the lived experiences of our services must lead this revolution. As a social worker, I am committed to working toward this through advocating for change in my agency by continuing my research on these social movements, collaborating with consumer/survivors, and furthering my narrative practice to help support AOP and anti-sanism.

Social workers and social work students working within a community mental health agency are strongly influenced by the medical model. The overpowering use of the medical model puts social workers at risk of oppressing service users due to workers' representation of 'normalcy' and individualism, which is a concept influenced by neoliberalism. Social workers have the opportunity to learn from consumer/survivors through changing their practice by having service users guide practices and listening to lived experiences and suggestions for change. Without this collaboration, mutual learning, and transparency specific to social location, social workers risk holding onto sanist attitudes, which contributes to the social oppression social

workers have been taught to resist. If social workers want to avoid the implication of being representatives of our flawed social system, social workers can locate themselves and recognize how their cultural and social experiences influence service users in order to put value to the complex experiences of madness. Furthermore, social workers will oppress service users due to sanism should they continue to only use medical model approaches without consideration, reflection and application of consumer/survivor and Mad perspectives.

Canada's dominant ideology of neoliberalism influences social work practice and service users of mental health due to the influence on the structures that make up our society. The current state of the mental health system must change as evident in the literature and from the voices and experiences of consumer/survivors. Becoming an ally and advocate of and for consumer/survivors and service users may begin to challenge the powerful and oppressive features of current mental health services evident in medical model treatment approaches. Integrating interventions and approaches such as narrative therapy or more holistic approaches, may help to respect the lives of consumer/survivors. Utilizing these approaches and challenging current oppressive practices is essential in order to work toward the recovery paradigm envisioned by consumer/survivors. The values, goals, and voices of the psychiatric consumer/survivor movement must lead this transformation in the community mental health sector.

Appendix A: Narrative Therapy Certification



SickKids
Centre for Community Mental Health
LEARNING INSTITUTE

SickKids Centre for Community Mental Health
Learning Institute

A CERTIFICATE OF COMPLETION FOR
THE FIVE DAY NARRATIVE THERAPY TRAINING PROGRAM

Is hereby granted to:

Alexandra Spears

In fulfillment of all requirements of the program.
Awarded on the 8th day of February in the year two thousand and twenty
October 12th, 2019 to February 8th, 2020
(30 hours)

Angela Kaushal
Director, Learning Institute
SickKids Centre for Community Mental Health

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