Explaining Mental Health Recovery in the Context of Structural Disadvantage: The Unrealised Potential of Critical Realism

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Abstract

Despite the acknowledgement that mental health inequalities are shaped by the interaction of macro-level (structural) and micro-level (individual, agentic) powers, dominant paradigms in mental health research have been ill-equipped to integrate those different levels of influence theoretically and empirically. As a result, an 'explanatory deficit' persists as to the causal mechanisms underpinning the impact of social inequalities on mental well-being, particularly mental health recovery. To redress this gap, critical realism has been put forward as a useful metatheoretical alternative. This paper begins by offering a succinct critique of extant mental health recovery research. Mental health recovery is problematised in relation to its dynamic embeddedness in contextual, including macro-structural, conditions. The core tenets and principles of critical realism are then invoked to address the identified philosophical and theoretical inadequacies. This paper argues that critical realism offers promise for explaining how inequality-generating mechanisms, such as social exclusion, may impede recovery. The analytico-conceptual potential of critical realism has remained largely untapped by the extant mental health scholarship. Critical realism offers a holistic and inclusive set of conceptual tools to re-examine the structure-agency nexus in order to advance mental health recovery and inequalities research, and an equity-based policy agenda.

Keywords: Health inequalities; mental health; recovery; critical realism; public health

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Introduction

As health inequalities deepen in many developed nations (Pickett & Wilkinson, 2010), understanding the impact of social exclusion and other forms of structural disadvantage on individuals' mental well-being has been highlighted as a priority for public health policy and research (Morrow & Malcoe, 2017). The accumulating evidence of the association between macro-structural factors, such as income inequality, and poor mental health has strengthened the mandate to '*deepen[ing] our understanding of how multiple inequalities are created, maintained and reproduced'* (International Social Science Council, the Institute of Development Studies, & UNESCO, 2016, p. 31). Arguably, this requires the thoughtful and critical use of theories and metatheories that adequately capture the processes (or mechanisms) via which inequality-generating 'forces' (at the macro-level) 'trickle down' to what are seemingly intrasubjective and intimate experiences of health, well-being and recovery(Pickett & Wilkinson, 2010; Tew et al., 2012). From a social justice perspective, it is incumbent on public health research to advance the understanding of how adverse socio-structural mechanisms engender and perpetuate inequitable life chances and disproportionately poor well-being in marginalised groups (Morrow & Malcoe, 2017). Simultaneously, such a research agenda should remain *humanistic* in its value orientation. Specifically, candidate (meta)theories should be consistent with the understanding of the person as an active agent with real and inherent motivations, beliefs and commitments, which are capable of affecting real change in a manner that is shaped by, but not determined by, social relationships and structures (Smith, 2011; Archer, 2003). Equipping health inequalities research with the theoretical robustness and inclusivity that match the complexity of social phenomena-that is the focus of the current conceptual piece.

The Explanatory 'Deficit' in Health Inequalities Research: The Case of Personal Recovery amidst Structural Disadvantage

While the existence of a set of fundamental causes of health inequalities, such as poverty, has been widely acknowledged, uncertainty remains over the causal pathways that mediate the effects of macro-structural 'forces' upon observable indicators of mental well-being (Dunn, 2012; Collins et al., 2015). As admitted by Shaw (2004, p. 414): *'This difficulty of disentangling and proving causal links is inherent to the study of social determinants of health, which tend to be multifaceted and confounded.'* This explanatory 'deficit' has been attributed to the inability of dominant research epistemologies and paradigms to capture the complexity and contingencies of *causal explanations*.(Popay et al., 1998; Somerville, 2013). With its preoccupation with the identification of an ever-expanding cluster of 'factors' and statistical associations, traditional positivist (e.g. epidemiological) research has painted a rather fragmented and inadequate picture of social causation that has been reduced to speculated law-like relationships between discrete, measurable 'variables' (Somerville, 2013). As Popay and colleagues (1998) note, traditional health inequalities research has largely failed to meaningfully account for, on a theoretical and a philosophical levels, the causal contributions of *both individual agency* and *social structure*, and their dynamic interactions and contextual embeddedness, to health outcomes (e.g. Popay et al., 1998).

This paper will contextualise this explanatory 'deficit' by critiquing the empirical study of *mental health recovery* (also called 'personal recovery' or simply 'recovery'). According to Anthony's (1993, p. 16) canonical definition, personal recovery reflects '[…] *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of*

living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness'. Over the last 20 years, mental health recovery has gained prominence as an emancipatory and person-centred philosophy of care and a guiding mental health policy principle in developed nations such as the U.K., the U.S., Canada and Australia (Slade et al., 2008; Farkas, 2007; New Freedom Commission on Mental Health, 2005; Department of Health, 2001; Scottish Government, 2012; US Department of Health and Human Services, 2006).

The rise of the recovery movement has taken place against the backdrop of increasing health inequalities and inequities in leading developed nations such as the U.K. and the U.S. (e.g. Shinn, 2010). In the context of persistent health and social inequalities, an urgent research and policy imperative has become understanding how to best support the personal recovery in persons facing social exclusion, economic deprivation, and other forms of structural disadvantage, including homelessness and severe poverty (UK Office of the Deputy Prime Minister 2004; US Department of Health and Human Services, 2006). Those policy imperatives necessitate the critical (re-)examination of dominant constructions of what recovery is, how it can be promoted, and how the person's social and biographic context shapes their recovery 'journey'. The next several sections engage in a critical analysis of some of the conceptual issues in the extant mental health recovery literature. It will be argued that, by and large, this body of research has failed to generate comprehensive, context-sensitive and mechanistic accounts of what enables and impedes recovery in the context of extreme socio-economic disadvantage, particularly poverty and homelessness.

Adverse socio-structural conditions based on marginalised socio-economic status (e.g. poverty), housing status (e.g. homelessness) and other markers of social division (e.g. race, gender, ethnicity, disability) have been commonly associated with experiences of social exclusion, discrimination and stigmatisation (Morrow & Malcoe, 2017). Those structural configurations, in turn, tend to hinder individuals' practical opportunities for social participation, citizenship and positive meaning-making and identity-building, among other crucial enablers of recovery (Leamy et al., 2011; Williams et al., 2015; Tew et al., 2012). The empirical literature on personal recovery has been criticised by some for neglecting the multifaceted roles of the disempowering and exclusionary socio-structural conditions that often impede recovery-promoting processes (Harper & Speed, 2014; Morrow & Weisser, 2012). A familiar example of this costly scholarly bias is the highly influential 'CHIME' framework of personal recovery, which is the product of a narrative synthesis of research into the experience of mental health recovery (Leamy et al., 2011). A close examination of the development of this framework reveals the glaring under-representation of research with individuals experiencing poverty, structural discrimination (for example, due to minority ethnic status), and other severe forms of social marginalisation and structural violence. As a result of this omission, the CHIME framework represents a cluster of decontextualised indicators or factors of personal recovery that offers little insight into the dynamic and interrelated mechanisms that account for the emergence (or non-emergence) of recovery in the context of structural disadvantage. Situating personal recovery within individuals' socio-structural contexts is instrumental in challenging reductionist notions that recovery is merely an intrasubjective, atomised faculty of the individual. Instead, personal recovery should more adequately be viewed as an emergent capacity borne out of the

individual's interaction with the '*broader web of social, political and economic contexts'* (Duff, 2016, p. 62).

In response to those gaps in the evidence base, Williams and colleagues (2015, p. 23) recommend that: *'Further research exploring the recovery experiences of individuals living with intersecting oppressions based on diagnosis, race, gender, sexuality, etc. is an important issue to address in future work.*' Similarly, Hopper (2007, p. 871) purports that *'[…] critical variables such as race, gender, and class tend to fade away into unexamined background realities, underscoring the defining centrality of psychiatric disabilities in these lives.'* Proponents of critical social justice argue that empirical inquiries of mental health recovery should be inseparable from the structural analysis of the economic, institutional and political injustices that 'recovering' individuals tend to systematically endure (Morrow & Malcoe, 2017).

Macro-structural 'forces' that may 'trickle down' to the level of the individual experience of mental health recovery (for instance, stigmatising societal attitudes, discriminatory housing policies or the medicalisation of mental illness), seem to be the manifestation of the rather 'invisible' (in an empirical sense) '*confluence of governmental, judicial and medical power'* (Pilgrim & Rogers, 1999, p. 14; Morrow & Malcoe, 2017). Yet, the effects of those structural configurations can be observed in what are often conceptualised as subjective and individualised experiences such as a negative self-concept, hopelessness, loss of meaning, self-neglect, passivity, dependence, and others (Vandekinderen et al., 2014). Arguably, with its preoccupation with the intrapsychic 'markers' of recovery, much of the theorising in the field has failed to account for the complex causality behind observable recovery-related outcomes (Fullagar & O'Brien, 2014).

The underspecification of the complex relationship between social inequalities and recovery processes can be attributed to the inadequate integration, philosophically, theoretically and methodologically, of the macro-structural and agential influences upon recovery. Noiseux and colleagues (2010) attribute this lack of substantive integration of the micro- and macro-perspectives of recovery to: (a) the inherent complexity of recovery, in that it is comprised of the synchronic occurrence of multiple processes (e.g. see the CHIME model; Leamy et al., 2011); and (b) the insufficient use of theories and metatheories to account for the multitude of influences upon recovery. The call for a more thoughtful and fine-grained application of social theory has been echoed by qualitative researchers in disability studies and in inequality studies (e.g. Williams, 2003). Noiseux and colleagues (2009) argue that: '*The qualitative studies have primarily employed research methods aimed principally at describing the phenomenon of recovery […] [which] does not provide sufficient clarification of the dynamics of recovery; that is, the reciprocal influence of the personal, environmental and organizational conditions that characterize the process.'* (p. 4-5). Therefore, the authors advocate the reorientation towards '*a dynamic conception of recovery'* (p. 3)-according to which recovery is neither *'activated or initiated solely by external factors'* (p. 3), nor merely an individualistic (intrapsychic) process (Noiseux et al., 2009).

Researchers and policy-makers should no longer 'sanitise' the concept and empirical study of recovery by neglecting the socio-structural context of individuals' lives, especially in the landscape of pervasive health and social inequalities. The structure-agency nexus has been both undertheorised and underresearched in relation to mental health recovery (Watson, 2012; Clifton et al., 2013; Yanos et al., 2007). This paper argues that the majority of empirical research on mental health recovery, rooted in the dominant empiricist (positivist and interpretivist)

paradigms, has 'stripped' recovery of its causal and contextual complexity by neglecting the impact of the structural configurations which individuals navigate. An alternative, complexity-consistent theorising is likely to be critical to explaining how individuals experiencing mental health difficulties can modify, challenge or reproduce existing social arrangements to effect more positive mental health outcomes (Hammersley, 2002).

Revitalising the Structure-Agency Dialectic in Mental Health Recovery Research: The Offerings of Critical Realism

This paper argues that *critical realism* (Bhaskar, 1989) offers the inclusive, non-reductionist and explanatory theorising about mental health recovery that accounts for the relevant exclusionary and other adverse social structures in society, and the inequality-generating mechanisms that they exert (Wainwright & Forbes, 2000; Dunn, 2012; Collins et al., 2015). Developed as both an antipode of and a mediator between its epistemological rivals (i.e. positivism, realism and constructivism), critical realism offers a rich ontological 'toolbox' that recognizes the independent but interacting causative effects of both macro-level (e.g. social structures) and micro-level (e.g. individual agency) entities (Bhaskar & Danermark, 2006; Bergin et al., 2008). Critical realism aims to produce *'[…] in-depth explanations of the 'causal mechanisms' and how they exert effect and if they have been triggered and under what circumstances they have been activated'* (Bergin et al., 2008, citing Sayer, 2000). As such, critical realism is arguably suited for generating explanatory accounts of complex, multi-layered and 'co-determined' phenomena (Bhaskar & Danermark, 2006).

Despite its potential, critical realism has remained severely *underused* in mental health and inequalities research. The small body of critical realism informed research with people with lived

experience of mental illness has begun to demonstrate the utility of this metatheoretical framework for the generation of in-depth, contextualised accounts of how socio-structural factors, such as stigmatisation and socio-economic exclusion, impede individuals' resources and capabilities necessary for achieving positive mental well-being (e.g. Tang, 2018; Bonnington & Rose, 2014).

The in-depth discussion of the ontological and epistemological attributes of critical realism is beyond the scope of this paper (Such theoretical discussions are available elsewhere, e.g. Williams, 2003; Bhaskar & Danermark, 2006; Forbes & Wainwright, 2001). Instead, several of the key tenets and principles of critical realism will be invoked to demonstrate its potential for addressing important theoretical and methodological inadequacies in mental health recovery research.

Depth Ontology

A distinctive feature of critical realism is that it re-centres ontology in the scientific pursuit of explaining complex social phenomena (Bhaskar, 1989; Sayer, 2000). A variant of scientific realism, critical realism acknowledges the existence of a reality that is independent of humans' perceptions and experiences of it, and assumes the impossibility of the direct access to the nature of reality by our senses, experiences, knowledge of theories (Bhaskar, 1989; Sayer, 2000). Those tenets are premised on the view of the stratified social reality (as opposed to the 'flat' ontology inherent to positivism and constructivism). The presupposition of a stratified social realm categorically challenges attempts to establish a direct link between what things 'really' are (in an ontological sense) and humans' ability to perceive them (Bhaskar, 1989). According to what Bhaskar (1989) terms '*depth ontology'*, reality is 'laminated' into three distinct yet interlinked domains: *the real* (relatively enduring and largely 'invisible' structures and causal liabilities)*, the*

actual (events that are the result of the activation of a structural liability, which could be either experienced and unexperienced) and *the empirical* (the level of experiences and observations). Satisfactory explanatory analyses of social phenomena must encompass all three domains-an insurmountable obstacle to traditional empiricist methods (Wainwright & Forbes, 2000).

Nature of Causality and Social Explanation

According to critical realism, causality is multi-layered and non-probabilistic. Within a depth ontology, causality is distinct from the direct, deterministic cause-and-effect relationships seen in 'closed' system (and akin to hypothetico-deductive research paradigms). Instead, causality is viewed as contingent, context-dependent and non-deterministic (Sayer, 2000). Critical realism subsumes an 'open systems' perspective (Bhaskar, 1998), whereby social phenomena are dependent on '*the continuously changing contextual conditions and the evolving properties of component within the structure.'* (Wynn & Williams, 2012, p. 793). To complicate matters further, social structures are, by definition, constantly reproduced by the actions of individual agents that comprise them, and they also interact with other social structures, which can influence whether their generative powers are enacted or not (Archer, 2003; Sayer, 2000). The goal of critical realism, therefore, is to identify *'tendencies of mechanisms to act within a specific contextual environment at a specified time.'* (Sayer, 1992, as cited by Wynn & Williams, 2012, p. 793). A 'tendency' (also called a 'demi-regularity') can be defined as the propensity of a given generative (or causal) mechanism to give rise to an event, given the presence of contextual enablement.

One of the main implications of this complex, stratified model of causality is that the search for causal mechanisms does not cease at the level of the empirical (e.g. the analysis of

statistical regularities or of self-report qualitative accounts). Instead, the critical realist analysis harnesses abstract modes of theorising (including *transfactual* or *retroductive reasoning*; Bhaskar, 1989; Danermark, 2002) about the 'deeper' layers of the social world-those unobservable but relatively enduring and causally efficacious structural configurations. Such *structural analysis* rejects the notion that causal explanation can be reduced to the properties of lower-level entities (e.g. as manifested in personal narratives and in statistical regularities; Sayer, 2000; Danermark, 2002). Thus, critical realism can overcome the explanatory inadequacies of traditional empiricist (quantitative and qualitative) mental health and inequalities research (Wainwright & Forbes, 2000).

Non-Reductionist Conception of Structure and Agency

Critical realism postulates that social structures and individual agency are distinct entities with independent causal powers (Archer, 2003; Craig & Bigby, 2015). According to the notion of *emergence*, social structures are *irreducible* to the actions of individual agents. Conversely, human agency is never fully determined by structural influences. According to Margaret Archer, for instance, individuals possess an inherent capacity to reflect upon the conditions of their existence, upon their past actions and upon their commitments, which, through their interactions with conducive contextual influences, can lead to human action, including self-change (Archer, 2003). Importantly, this non-reductionist view of causality allows for entities at both the macro- (e.g. social structures, organisations, interventions) and the micro- (e.g. human cognition, motivation, ideation and actions) to have analytically separable causal powers ('double inclusiveness'; Bhaskar & Danermark, 2006; Archer, 2003). This conception of the agency-structure nexus avoids the dangers of neglecting the influence of social structures and thereby

succumbing to the neoliberal philosophy of individual 'responsibilisation' (Harper & Speed, 2014). Simultaneously, critical realism avoids the *underemphasis* of individual causal powers, particularly with regards to human volition and capacity to reflect, act upon and transform the conditions of existence, which would risk supporting the anti-humanistic view that *'...people [are] cultural dopes, passively progressing along a predetermined path.'* (Parsell et al., 2016, p. 250, citing Houston, 2009; Abel & Frohlich, 2012). A critical realism informed research, therefore, is equally focused on exploring '*the impingements of structure on individual health and well-being'* and *'the tactics devised by individuals to deal with these very impingements.'* (Angus & Clark, 2011, p. 3).

'Walking the Talk': Implementing Critical Realism in the Conceptualisation and Empirical Analysis of Personal Recovery

A persistent barrier to popularising critical realism as a viable metatheoretical alternative for (mental) health and inequalities research has been its practical application. Specifically, framing recovery as a research problem in a critical realism informed study has been attempted by few (See Tang (2018) and Kartalova-O'Doherty and Doherty (2011), for two rare examples).

Here, a succinct example will be offered of a critical realist framing of personal recovery in the context of chronic homelessness-inspired by the current author's own qualitative research with homeless populations experiencing mental health difficulties. Homelessness has often been characterised as a 'wicked' socio-political issue, which tends to co-occur with other forms of disadvantage including substance use problems, serious mental illness, poverty, interpersonal violence, discrimination, and others (e.g. Somerville, 2013; Shinn, 2010). Homelessness has commonly been ascribed 'complex causality' that involves both structural and individual causes (Fitzpatrick, 2005; Somerville, 2013). Furthermore, the experience of homelessness is in itself

multidimensional and can encompass the physical (lack of physical shelter and safety), social (lack of a safe base to build social relationships), existential (lack of ontological security and meaning in life), and other domains (Somerville, 2013). This makes the study of co-occurring homelessness and mental health difficulties an especially fertile arena for critical realist analysis.

The following illustration of the application of some of the principles and concepts of critical realism is non-prescriptive but rather suggestive of the diverse possibilities afforded by its rich ontology. A multi-level or '*laminated*' (Bhaskar & Danermark, 2006) explanation of what enables and constrains personal (mental health) recovery in the context of homelessness is likely to require the researcher to trace generative mechanisms at several levels-including at the individual, interactional, organisational, cultural and structural 'layers' of the social realm (adapted from Bhaskar and Danermark (2006):

I. The individual (or micro-) level captures processes that are primarily biological, cognitive, psychological or biographical in nature.

The effects of psychiatric medication on the individual's alertness and energy levels, which, in turn, may affect how the individual engages in valued social activities, are a consequence of essentially biological (or physiological) processes. The individual's inherent faculties of reasoning, decision-making and planning-which are instrumental in defining and setting recovery-oriented goals- are examples of cognitive and psychological processes. Lastly, the individual's unique constellation of life experiences-such as physical or psychological trauma, admission into institutional care, bereavement and other personal losses-is also likely to play a significant role in influencing the individual's resources (e.g. social capital) that can facilitate recovery.

Considered in isolation, those individual-level processes reveal little about why the phenomenon under scrutiny (in this case, recovery) is enabled or constrained (Somerville, 2013). In an open, complex social system, observable outcomes tend to be the result of the complex interlacing of multiple causal influences within and across social strata. For instance, productive, context-sensitive analytic questions may be: (1) How does living on the streets in a state of constant insecurity and vulnerability to violence (i.e. structural and interactional factors) affect the individual's access to psychiatric medication, as well as the individual's likelihood of choosing to consume the medication with its known wanted and unwanted physiological effects?; (2) How does the individual's informed decision *not* to take psychiatric medication so as to maintain their level of vigilance and stamina, which may be adaptive to the individual's safety on the streets, affect their negative symptoms (e.g. intrusive voice-hearing), and, consequently, their capabilities of insight, critical thinking and self-directed action?; (3) What personal meaning does the individual attribute to the psychological trauma experienced, and how does this experience influence how the individual engages with their case worker (i.e. an interactional factor)?

II. The interactional (or dyadic) level refers to the relational processes that emerge out of the individual's interactions and relationships with others.

Reciprocity, respect, recognition and other emergent properties of human relationships are instrumental for enabling individuals to perform personally and socially valued roles, as well as to rebuild a positive social identity. Those processes of identity-building and social connectedness have been shown to be among the core empirical indicators of personal recovery (Leamy et al., 2011). In the context of homelessness, however, those recovery-promoting processes are often severely disrupted (e.g. Karadzhov, Yuan, & Bond, 2019). For many,

homelessness is a profoundly alienating and dehumanising experience, which can impede the individual's capabilities of maintaining meaningful social relationships. This further motivates the multi-level analysis of the conditions under which recovery-promoting affective and other relational processes emerge.

III. At the organisational level, pertinent analytic questions may concern the degree of person-centredness and service integration that a homeless services provider has, and its impact on clients' service engagement, well-being and recovery. Service-providers' stigma, as well as the tendency to medicalise the social distress of clients, is an example of a meso-level causal influence that may interact with processes occurring at any of the other levels to ultimately facilitate or impede recovery.

IV. Finally, at the cultural and structural levels, macro-social and economic factors and processes such as housing availability, social and public health policies, societal attitudes towards homelessness and the mentally ill, culturally sanctioned gender relations, economic recessions, poverty and austerity may all be significantly implicated in shaping individuals' homelessness pathways as well as their recovery trajectories (Somerville, 2013). Consistent with critical realism, those macro-level 'forces' do not act in a deterministic fashion, but instead interact with a range of individual, relational and organisations mechanisms to produce (or not) observable effects on individual well-being and recovery.

To identify such plausible macro-level causal entities and their generative mechanisms and associated outcomes, the researcher needs to employ higher-order modes of analytic abstraction such as abductive and retroductive (or *'transfactual'*) reasoning. Abductive reasoning enhances the explanatory remit and utility of the analysis by reinterpreting the data through the lens of

existing theory (or theories). Transfactual reasoning, on the other hand, aims to identify the essential (or 'necessary') conditions, causal structures and powers that make the phenomenon possible (Danermark et al., 2002). Because those causal entities exist in the domain of the 'real' and are therefore 'intransitive' and operate independently of our perceptions of them, they cannot be identified empirically but only inferred analytically (Danermark et al., 2002).

Let us take, for instance, an experiential category-such as *'boredom'*-which has hypothetically emerged as a major theme from the inductive (bottom-up, experience-near) analysis of qualitative interviews with participants who were homeless. Invoking transfactual reasoning, the researcher will utilise the inductively derived meaning units as heuristics in the process of 'mining' the plausible deeper social structures that shape the participants' reported experiences and subjective knowledge. Pertinent analytic questions, then, might be: What does the chronic and debilitating boredom that the participants report presuppose?; What in the social and politico-economic order makes those experiences possible?; What is it about social relations in society that may foster (or disrupt) the participants' profound experiences of boredom?; Is boredom a manifestation of the participants' 'mediated knowledge' of the macro-political processes of social exclusion and misrecognition that negatively impact those without a home?

In its search of causally efficacious configurations and conjunctions between entities across different planes of the social, a critical realist analysis seeks to illuminate candidate mediating structures, processes and other entities, including contextual contingencies, that could account for the outcomes under scrutiny, in the complex open social system (See Archer (2003); Blom & Morén, (2011). As eloquently argued by Bhaskar and Danermark (2006), critical realism empowers the researcher to think '*transfactually*' of the mechanisms that co-determine the phenomenon of interest, which minimises the risk of epistemological and theoretical

reductionism. This analytic stance can therefore open up the possibilities for conceptualising *and explaining* recovery as a necessarily complex, co-determined phenomenon.

Implications for Public Mental Health, Health Policy, and Health Inequalities Research

Critical realism informed research holds the potential to **'***more cogently mine social inequalities as they pertain to mental health'* (Morrow & Malcoe, 2017, p. 47). A critical realist informed analysis should seek to explicate the entirety of the phenomenon of recovery without succumbing to biological, psychological or sociological reductionism. To achieve this, one needs to synergistically examine how *'contingencies and context'*, '*personal and collective meanings'*, and '*material forces'* may be implicated in the recovery process (Pilgrim & McCranie, 2013, p. 168). As David Pilgrim (2014 p. 9) argues, in order to obtain a '*complex ontological picture'* of mental health related phenomena, one needs to combine a '*meaning-focused approach'* with an analysis of '*distal and supra-personal'* influences. Crucially, empirical investigations of complex, *'necessarily laminated'* (Bhaskar, 1989) phenomena need to be situated within an explicit ontology that allows for an enhanced understanding of the links between structures, causal powers and liabilities, contexts and outcomes, across different social strata (Bhaskar, 1989; Sayer, 2000).

A critical realism infused research agenda has the potential to generate substantive propositions as to *how* actions on the social determinants of health are likely to enable or facilitate processes (intrapsychic, relational, organisational and structural) that are conducive to the mental health recovery of persons experiencing multiple, interlocking forms of structural disadvantage. Identifying and preventing the *'...structures and processes that differentially affect people's chances to be healthy within a given society....*' are crucial to an equity-focused

research and policy agenda (Östlin et al., 2011, p. 2). Research and policy efforts should concentrate on removing structural configurations (e.g. institutional, political, ideological, organisational) that tend to act as '*inequality-generating mechanisms'* (Ng & Muntaner, 2014)which, for instance, can constrain people's opportunities for citizenship, social inclusion and political empowerment, and therefore stifle the opportunities for achieving a productive, satisfying and meaningful life, i.e. the pillars of personal recovery (Williams et al., 2015; Anthony, 1993). As Manuel (2006, as cited by Norris et al., 2010, p. 196) states, *'...good public policy takes stock of where people are located, where they want to be (the good life), and how the good society can build bridges to help them get there.'*

Comprehensive and critical knowledge of how both structural conditions and individual agency are implicated in individuals' recovery trajectories should underpin public mental health interventions. The focus of critical realism on the role oppressive structures (e.g. poverty, discrimination, the political economy) on individuals' capacity for self-determination, autonomy and self-fulfilment has an inherent social justice intent (McNeill & Nicholas, 2017). The explanatory accounts that critical realists aim to develop, therefore, have the potential to instruct ameliorative change (Hammersley, 2002; Houston, 2010; McNeill & Nicholas, 2017). Mental health promotion policy and practice should combine endeavours to remove oppressive structural configurations with efforts to stimulate '*structurally transformative'* individual agency (Abel & Frohlich, 2012; Rütten & Gelius, 2011).

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