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Personal recovery and socio-structural disadvantage: A critical conceptual review

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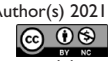

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Abstract

Despite its seeming breadth and diversity, the bulk of the personal (mental health) recovery literature has remained strangely 'silent' about the impact of various socio-structural inequalities on the recovery process. Such an inadequacy of the empirical literature is not without consequences since the systematic omission or downplaying, at best, of the socio-structural conditions of living for persons with lived experience of mental health difficulties may inadvertently reinforce a reductionist view of recovery as an atomised, individualised phenomenon. Motivated by those limitations in extant scholarship, a critical literature review was conducted to identify and critique relevant research to problematise the notion of personal recovery in the context of socio-structural disadvantage such as poverty, homelessness, discrimination and inequalities. The review illuminates the scarcity of empirical research and the paucity of sociologically-informed theorisation regarding how recovery is shaped by the socio-structural conditions of living. Those inadequacies are especially pertinent to homelessness research, whereby empirical investigations of personal recovery have remained few and undertheorised. The gaps in the research and theorising about the relational, contextual and socio-structural embeddedness of recovery are distilled. The critical review concludes that personal recovery has remained underresearched, underproblematised and undertheorised, especially in the context of homelessness and other forms of socio-structural disadvantage. Understanding how exclusionary social arrangements affect individuals' recovery, and the coping strategies that they deploy to negotiate those, is likely to inform anti-oppressive interventions that could eventually remove the structural constraints to human emancipation and flourishing.

Keywords

disadvantage, homelessness, mental health, personal recovery, social theory

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Introduction

Personal recovery (or simply 'recovery') is a multifaceted and fluid concept, which is often seen as its inherent strength (Hopper, 2007; Pilgrim and McCranie, 2013). This inclusive and holistic nature of recovery is often seen as reflective of its person-centred and emancipatory roots and philosophy (Pilgrim and McCranie, 2013). The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) provides an inclusive definition of recovery from serious mental illness and/or substance use problems as '[a] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential' (p. 3). Supporting each client's recovery has been affirmed as a policy objective in the last 20 years in both the U.K. (including Scotland) and the U.S. (Department of Health, 2011; McWade, 2016; Scottish Government, 2017; Slade et al., 2008; US Department of Health and Human Services, 2003).

Realising individuals' recovery requires a shift of the clinical focus away from their deficits and towards their choice, inner assets and journeys of growth and self-discovery (Slade, 2009). Rather than as 'passive recipients of rehabilitation services', Deegan (1988: 1) argues, individuals recovering from mental illness should be treated as self-directed persons who strive to re-build a sense of meaning and purpose and a positive sense of self, despite experiencing occasional setbacks, doubts and vulnerability. The recovery notion is imbued with therapeutic optimism, hope and humanism (Slade, 2009). Critically, the personal transformation inherent to recovery cannot be 'programmed'; it is contingent upon the individual's proactive engagement with their own values, beliefs and principles, and with the objective conditions of existence (Deegan, 1988; McLean, 1995).

The diverse corpora of qualitative research – including ethnographic, oral history, narrative and participatory research – have played a central role in foregrounding lived experience knowledges of recovery, highlighting its contextual embeddedness and challenging professionalised, medicalised and other reductionist constructions of recovery (Borg and Davidson, 2008; Davidson et al., 1997, 2005; Foster et al., 2006; Grant, 2014; Rennick-Egglestone et al., 2019; Topor et al., 2011). Such research has expanded the understanding of the 'storied complexity' (Grant et al., 2015, p. 1) of recovery, its multidimensionality, its constitutive 'properties', 'processes' and 'elements', as well the various factors enabling and hindering recovery. Those facilitators and hinderers refer to both the individual's internal beliefs, predispositions and practices, and the individual's wider context – including relationships, support services, institutions and the wider culture and society (Bonney and Stickley, 2008; Drake and Whitley, 2014; Jacob et al., 2017; Leamy et al., 2011; Onken et al., 2007; Stuart et al., 2017; Tew et al., 2012; Topor et al., 2011).

Despite their seeming breadth and inclusiveness, and important contributions made to understanding the nature and dimensions of recovery, those literatures share several important caveats. Common methodological problems include the small number of included studies in reviews (e.g. Ness et al., 2014; Shepherd et al., 2016a, 2016b; Stickley and Wright, 2011a); and the inadequate documentation and discussion of participants' socio-demographic characteristics and their relevance for recovery (e.g. Jacob et al., 2017; Leamy et al., 2011; Stickley and Wright, 2011a). The inadequate contextualisation of the included samples – in terms of their socio-economic status, ethnicity, gender,

housing status and others – limits the ability to critically examine the extent to which those findings apply to groups experiencing various forms of social disadvantage and inequalities. Accordingly, in the majority of relevant reviews, there is a lack of detailed critical consideration of how multiple forms of oppression and marginalisation could intersect and interact to influence the experience of recovery. The importance of housing, for instance, is only briefly mentioned in a handful of reviews (e.g. Drake and Whitley, 2014; Topor et al., 2011). In those reviews, however, detailed discussions of what aspects of housing or homelessness may impact on recovery are missing.

The extensive evidence base on the relationship between mental health, socio-economic status and social inequalities has not been adequately harnessed to inform and problematise the dominant approaches to conceptualising and studying recovery (Pickett and Wilkinson, 2010; Pilgrim, 2008; Thoits, 2010). Despite the evidence for the impact of a multitude of social and structural factors on recovery, there is a need for more research into how experiences of recovery are affected by discrimination and other oppressive social structures and models of service provision (Tew et al., 2012; Topor et al., 2011).

Neglecting the roles of inequalities, disadvantage and other structural conditions risks succumbing to a reductionist and potentially harmful view of recovery, and mental well-being, respectively, as constituting little more than a function of individuals' cognition, emotions and volition (Harper and Speed, 2012; Hopper, 2007; Rose, 2014; Watts, 2014; Woods et al., 2019). There is a need, therefore, to comprehensively examine how individuals exercise and sustain their recovery in the face of systemic adversity. To the author's knowledge, no review to date has been specifically dedicated to personal (mental) health recovery in the context of socio-structural disadvantage such as poverty, homelessness and/or other types of social marginalisation. Motivated by those research and theoretical inadequacies, a critical literature review was conducted to identify and critique relevant research to problematise the notion of personal (mental health) recovery in the context of socio-structural disadvantage such as poverty, homelessness, discrimination, inequalities and others.

Methods

The critical review approach was deemed fit-for-purpose because of its utility for extracting and synthesising evidence from diverse sources – empirical and theoretical (Grant and Booth, 2009). Critical reviews are also well suited for the in-depth, critical appraisal of a research field, concept or problem, with the ultimate goal of helping generate critique, conceptual innovation and testable hypotheses, as well as identify new research directions (Grant and Booth, 2009; Huff, 2008).

Searching and screening relevant sources

An iterative and purposeful sampling of the literature was conducted (Benoot et al., 2016). A pragmatic alternative to exhaustive sampling methods, *purposeful sampling* techniques entail the selection of information-rich cases for in-depth study, which helps achieve an enhanced understanding rather than empirical generalisations

(Benoot et al., 2016; Patton, 2002). This approach is consistent with the aims of this review to generate an insightful and constructive evidence-based critique by synthesising and appraising a representative 'cross-section' of relevant empirical, conceptual and meta-level (e.g. reviews) works. The search aimed to '[. . .] identify most significant items in the field' (Grant and Booth, 2009: 94), without over-privileging certain sources over others based on their underlying paradigms, epistemologies, study designs or reporting quality.

Two main purposeful sampling techniques were applied: *intensity sampling* and *theoretical sampling* (Benoot et al., 2016). Intensity sampling involves identifying '[i]nformation-rich cases that manifest the phenomenon intensely [. . .]', which facilitates a more comprehensive understanding of the phenomenon (Benoot et al., 2016: 3). The current focus on homelessness, an extreme and complex form of socio-structural disadvantage, allowed for the in-depth exploration of recovery amidst disempowering and marginalising social conditions. Theoretical sampling, on the other hand, mandates the identification of sources that showcase theoretical constructs that are vital to understanding the phenomena under study (Benoot et al., 2016). This review purposefully searched relevant studies for sociological concepts such as intersectionality, capabilities, citizenship and other potentially generative constructs for problematising and expanding the notion of recovery.

The literature searches were conducted iteratively between 2017 and 2019 in several electronic databases, including Scopus, PsycINFO, MEDLINE, CINAHL Plus and Social Services Abstracts. This selection of electronic databases reflected the interdisciplinary focus of the literature on recovery and homelessness, which includes the psychiatric, psychological, sociological, social work, nursing, health policy and other literatures. Concepts such as 'recovery', 'homelessness' and 'social exclusion' tend to be contested terms, with no universally accepted definitions (Hsieh, 2016; Morgan et al., 2007; Slade et al., 2012). Therefore, relying on a pre-planned, restricted set of search terms is likely to exclude potentially relevant sources (Tew et al., 2012). In addition, the extremely limited number of empirical investigations in areas such as recovery and co-occurring homelessness necessitated a more flexible and inclusive engagement with the relevant theoretical and empirical scholarship (Huff, 2008).

Accordingly, broad-based, free-text search terms were used (e.g. 'recovery', 'experience'; 'homeless/ness'; 'mental', 'inequality', 'poverty', 'disadvantage', 'disparities'), in addition to relevant methodological filters (e.g. 'qualitative', 'mixed*', 'ethnograph*', 'interview*', 'randomised', 'trial' and others; Shaw et al., 2004). Commonly used search limits were: English language; peer-reviewed; published in or after the year 2000; article, review, book chapter or editorial; and the subject areas (in Scopus), Medicine, Social Sciences, Health Professions, Nursing, Psychology and Multidisciplinary. To maximise the retrieval of potentially useful sources, bibliographic searches and citation searches were also carried out. To identify the most influential concepts in relation to the review objectives, the theoretical literature was also searched (Booth, 2016; Huff, 2008).

To be considered for inclusion, sources had to be within the aforementioned limits; be qualitative, mixed-method or quantitative, empirical or non-empirical evidence and primary or secondary evidence; explicitly discuss recovery in the context of mental health difficulties, or have a clear relevance to understanding recovery in this population; and

explicitly discuss one or more forms of socio-structural disadvantage or other relevant social factors in relation to mental well-being and/or recovery. Potentially eligible sources were also evaluated based on the extent to which the source facilitated theoretical insight by, for example, applying a conceptual framework in a novel way, or proposing a novel construct.

Quality appraisal, data extraction, synthesis and reporting

No formal quality appraisal of the articles discussed in this review was conducted. Evidence sources were critically evaluated as part of the remit of the review based on their methodological and conceptual contributions to the empirical and theoretical topics that form the review objectives (Grant and Booth, 2009). The mapping and synthesis of the included studies were aided by the qualitative data analysis software (QDAS), NVivo 12 (QRS International, 2020).

The non-exhaustive literature search and the lack of formal quality appraisal that are characteristic of critical reviews increase the risk of disciplinary, philosophical, theoretical and other biases influencing the conduct and implications of the review. Those limitations should be considered when assessing the transferability of the review findings.

The findings are reported narratively and in a tabular format in four main parts. First, a descriptive overview and a mapping of included sources are presented highlighting the representation of various social factors within those studies. This aims to help identify gaps in the research focus on recovery and socio-structural disadvantage and aid researchers in navigating this heterogeneous and multidisciplinary corpus of empirical and theoretical literature. Second, pertinent conceptual critique of research, or the paucity thereof, on recovery amidst disadvantage is presented. Third, a representative sample of the identified empirical literature is concisely reviewed – focusing on how those studies have illuminated how a range of socio-structural forces exerted (mostly constraining) effects on individuals' recovery. In the fourth main section, the identified empirical and theoretical literature on homelessness and mental health recovery is reviewed to illustrate the main lines of critique distilled from the broader literature on mental health and disadvantage in this largely neglected area of research.

Results

Overview and mapping of included sources

A total of 40 evidence sources spanning the fields of sociology, psychiatry, nursing, social work, feminist and social justice studies, geography, human rights and other health and social sciences were included:

- Twenty-one primary empirical (mostly qualitative) studies: Armour et al. (2009); Benbow et al. (2011); Duff (2016); Fullagar and O'Brien (2014); Jensen and Wadkins (2007); Kidd et al. (2014); Kirkpatrick and Byrne (2009); Kirst et al. (2014); Lafrance and Stoppard (2006); O'Brien (2012); Padgett (2007); Padgett et al. (2008); Padgett et al. (2013); Padgett et al. (2016); Patterson et al. (2013);

Piat et al. (2017); Smith et al. (2015); Watson (2012); Williams et al. (2015); Zerger et al. (2014a); and Zerger et al. (2014b);

- Nine literature reviews: Bonney and Stickley (2008); Drake and Whitley (2014); Leamy et al. (2011); Livingston and Boyd (2010); Llewellyn-Beardsley et al. (2019); Onken et al. (2007); Stuart et al. (2017); Tew et al. (2012); and Topor et al. (2011); and
- Ten conceptual papers, theoretical reflections, editorials and other types of non-empirical work: Burns (2009); Clifton et al. (2013); Fisher and Freshwater (2014); Harper and Speed (2012); Hopper (2007); Morrow and Weisser (2012); Pilgrim (2008); Rose (2014); Woods et al. (2019); and Yanos et al. (2007).

In accordance with the aims and objectives of the current review, and inspired by Holman et al.'s (2018) literature trend analysis of the consideration of social context in health behaviour interventions, a QDAS-assisted mapping of key concepts related to social factors and social context that are discussed, at least minimally, in relation to people with mental health difficulties in the included sources was conducted (See 'Table 1'). The Text Query and Word Tree features of NVivo 12 aided the mapping. Twenty-eight clusters of social factors were considered in the mapping – including gender, ethnicity, class, poverty, housing and homelessness, services and policies, inequalities, structural factors and others. This mapping provides an insight into the scope and breadth, foci, disciplinary and theoretical orientation and representation and inclusiveness of included sources. It also facilitated the identification of gaps in empirical research and in conceptual emphasis in relation to mental health recovery.

The second column of 'Table 1' offers examples of *how* those concepts are used in the source material and, therefore, helps illuminate the dimensionality of the respective social factors those concepts signify. For instance, included studies considered several intersections of forms of disadvantage in relation to the well-being and recovery of persons with mental health difficulties such as those of racial oppression and mental health stigma (Armour et al., 2009); racism, poverty, motherhood and homelessness (Benbow et al., 2011); gender and ethnicity (Kidd et al., 2014); and diagnosis, race, gender and sexuality (Williams et al., 2015; See 'Table 1'). Furthermore, included sources considered structural, economic, political, income, health, gender and other types of inequalities and inequities. Also, collectively, the sources discussed the influence of a range of discourses on recovery–namely neoliberal, hegemonic, biomedical and other professionalised discourses.

The third column of 'Table 1' indicates how many of the included sources discussed directly or indirectly, and at least to a minimal degree, those social factors and contexts in relation to mental well-being and/or recovery. Finally, the fourth column features sources that address each cluster of factors in exemplary depth and detail.

Among the most commonly discussed social factors were found to be social support and relationships; mental health and other policies and services; stigma; socio-economic factors; home and housing and others (See 'Table 1'). In contrast, the least commonly addressed social factors of those examined in the mapping exercise relate to intersectionality; occupation (beyond employment); race; class; citizenship; gender; social or community inclusion and exclusion; broader health inequities, and others ('Table 1'). The

Table 1. A mapping of common social factors and social contexts discussed in relation to people with mental health difficulties within the included studies.

Social factors and social contexts	Examples of contexts within which the words or phrases occur among included sources	Number of sources ($N = 40$)	Exemplary sources
Citizenship	Full/active/social/neo-liberal/individualised citizenship; normative notions of citizenship	10	Fisher and Freshwater, 2014; Hopper, 2007; Pilgrim, 2008; Williams et al., 2015
Class	[. . .] race, ethnicity, gender, religion, ability, sexual orientation and class as interactive forces rather than independently functioning categories [. . .]' (Benbow et al., 2011); class injustice	15	Burns, 2009; Pilgrim, 2008
Culture/cultural/culturally/culture-specific	Cultural stereotypes/environment/sensitivity/ processes/rituals/capital/context/reintegration/ diversity; culturally-responsive models of recovery; patriarchal culture	31	Kidd et al., 2014; Zerger et al., 2014a; Armour et al., 2009; Morrow and Weisser, 2012
Disadvantage/disadvantaged	Material and symbolic disadvantage; economic/ concentrated/structural/social/health/epistemic disadvantage	15	Yanos et al., 2007; Padgett et al., 2008; Fisher and Freshwater, 2014
Discourses	Dominant/neoliberal/recovery/resilience/hegemonic/ biomedical discourses	11	Fisher and Freshwater, 2014; Fullagar and O'Brien, 2014; O'Brien, 2012; Harper and Speed, 2012; Lafrance and Stoppard, 2006; Llewellyn-Beardsley et al., 2019; Rose, 2014; Woods et al., 2019
Discrimination/discriminated/discriminatory /discriminating	Discriminating against people of colour/those with mental disabilities/attitudes towards the mentally ill; institutional/structural/perceived discrimination	21	Zerger et al., 2014a; Kidd et al., 2014; Burns, 2009; Livingston and Boyd, 2010; Benbow et al., 2011; Clifton et al., 2013; Tew et al., 2012
Employment/unemployment/unemployed	[. . .] combinations of problems such as unemployment, discrimination, poor skills, low incomes [. . .]' (Clifton et al., 2013)	26	Benbow et al., 2011; Clifton et al., 2013; Drake and Whitley, 2014; Hopper, 2007; Livingston and Boyd, 2010; Tew et al., 2012
Ethnicity/ethnic/minority	Racial and ethnic discrimination; ethnic minorities; double stigma among ethnic minority groups	20	Armour et al., 2009; Kidd et al., 2014; Zerger et al., 2014a; Leamy et al., 2011; Tew et al., 2012

(Continued)

Table 1. (Continued)

Social factors and social contexts	Examples of contexts within which the words or phrases occur among included sources	Number of sources ($N = 40$)	Exemplary sources
Gender/gendered	Gender expectations/inequities/relations/norms/roles/stereotypes; the intersections of gender, ethnicity and racialised identities	18	Benbow et al., 2011; Burns, 2009; Fullagar and O'Brien, 2014; O'Brien, 2012; Kidd et al., 2014; Lafrance and Stoppard, 2006
Home/housing	Interim/permanent/stable/transitional/supportive housing; Housing First; housing arrangements/stability/systems	33	Padgett, 2007; Benbow et al., 2011; Kirst et al., 2014; Watson, 2012; Piat et al., 2017; Kirkpatrick and Byrne, 2009
Homeless/homelessness	Homeless services/individuals/mentally ill/outreach/identity	20	Benbow et al., 2011; Patterson et al., 2013; Kirst et al., 2014; Zerger et al., 2014a
Inequality/inequalities/unequal/inequity/inequities/disparity	[. . .] the collective, structural experiences of inequality and injustice [. . .]' (Harper and Speed, 2012); structural/economic/political/income/health/societal inequalities; durable inequities; gendered and material inequities	18	Burns, 2009; Fullagar and O'Brien, 2014; Harper and Speed, 2012
Intersectionality/intersectional/intersection	The intersection of racial oppression and stigma specific to mental illness (Armour et al., 2009); '[. . .] barriers related to motherhood status intersected with racism, stigma of mental illness, poverty, language barriers, and homelessness' (Benbow et al., 2011); '[. . .] the intersection of gender and ethnicity with [the] recovery experiences [. . .]' (Kidd et al., 2014); '[. . .] the recovery experiences of individuals living with intersecting oppressions based on diagnosis, race, gender, sexuality [. . .]' (Williams et al., 2015)	12	Benbow et al., 2011; Morrow and Weisser, 2012; Kidd et al., 2014; Livingston and Boyd, 2010; Padgett et al., 2016; Zerger et al., 2014a
Legal	[. . .] environments of discrimination that are structured through legal, medical and psychological practices and policies'. (Morrow and Weisser, 2012); legal restrictions and institutionalised poverty	12	Yanos et al., 2007; Morrow and Weisser, 2012

(Continued)

Table 1. (Continued)

Social factors and social contexts	Examples of contexts within which the words or phrases occur among included sources	Number of sources ($N = 40$)	Exemplary sources
Marginalisation/marginalised	Social and cultural marginalisation; material inequalities that result from marginalisation	20	Benbow et al., 2011; Clifton et al., 2013; Harper and Speed, 2012; Patterson et al., 2013
Occupation/occupational	Occupational and rehabilitation services; occupational and community-based activities; 'Removal of barriers to accessing social, family-related, accommodation, educational, occupational, and recreational opportunities and to full participation for with mental disabilities'. (Burns, 2009)	8	Leamy et al., 2011; Tew et al., 2012; Topor et al., 2011; Burns, 2009
Oppression/oppressed/oppressive	[. . .] the complex dimensions of oppression and privilege based on race'. (Benbow et al., 2011); racial oppression; experiences of oppression and resistance	21	Armour et al., 2009; Benbow et al., 2011; Morrow and Weisser, 2012; Fisher and Freshwater, 2014; Kidd et al., 2014; Onken et al., 2007; Tew et al., 2012
Places/spaces/assemblage/environment/atmosphere	People, place and things; enabling social environments; assemblage of health; recovery assemblage; safe spaces	30	Duff, 2016; Piat et al., 2017; Smith et al., 2015; Kirkpatrick and Byrne, 2009; Kidd et al., 2014; Onken et al., 2007; Padgett et al., 2013; Williams et al., 2015
Political/politics/policies	Mental health/government/agency/shelter/recovery policies; recovery-as-policy; political economy/dimensions/engagement/factors/forces/impact/environment	33	Benbow et al., 2011; Pilgrim, 2008; Harper and Speed, 2012; Morrow and Weisser, 2012; Williams et al., 2015
Poverty/poor/impoverished/impoverishment	Neighbourhoods with concentrated poverty; alleviating poverty and inequality; anti-poverty initiatives promoting recovery	22	Benbow et al., 2011; Burns, 2009; Morrow and Weisser, 2012; Padgett et al., 2008; Padgett et al., 2016; Yanos et al., 2007; Zerger et al., 2014a
Race/racial/racism	Ethno-racial discrimination in employment and housing; racial disparities in health; racial oppression and stigma	19	Armour et al., 2009; Benbow et al., 2011; Kidd et al., 2014; Zerger et al., 2014a

(Continued)

Table 1. (Continued)

Social factors and social contexts	Examples of contexts within which the words or phrases occur among included sources	Number of sources ($N = 40$)	Exemplary sources
Services	Mental health/behavioural health/human/psychiatric/recovery/rehabilitation/community services; independence from services; culturally appropriate services	36	Bonney and Stickley, 2008; Watson, 2012; Clifton et al., 2013; Yanos et al., 2007; Kirst et al., 2014; Armour et al., 2009; Drake and Whitley, 2014; Harper and Speed, 2012; Hopper, 2007; Llewellyn-Beardsley et al., 2019
Social support/relationships/networks	Social/peer support/positive/personal/reciprocal/therapeutic/personalised/emotional/power relationships	39	Tew et al., 2012; Padgett et al., 2008; Onken et al., 2007; Topor et al., 2011; Drake and Whitley, 2014
Social/community exclusion	The forces of social exclusion (prejudice, stigma and institutional discrimination against those with mental health problems)	12	Clifton et al., 2013; Padgett et al., 2016; Bonney and Stickley, 2008; Pilgrim, 2008
Social/community inclusion	Inclusive communities; multisystemic interventions promoting social inclusion; barriers to social inclusion	13	Clifton et al., 2013; Tew et al., 2012
Socio-economic/economic/financial/income	Socio-economic influences/factors/forces/discrimination	25	Burns, 2009; Clifton et al., 2013; Harper and Speed, 2012; Morrow and Weisser, 2012; Padgett et al., 2016; Stuart et al., 2017; Yanos et al., 2007
Stigma/stigmatisation/stigmatised	Mental illness/structural/institutional stigma; stigma as a form of oppression; double stigma	31	Livingston and Boyd, 2010; Armour et al., 2009; Benbow et al., 2011; Burns, 2009; Jensen and Wadkins, 2007; Tew et al., 2012; Williams et al., 2015
Structural	Structural barriers/forces/inequalities/contexts/dimensions/factors/disadvantage/discrimination/injustice; structural facilitators of recovery	20	Padgett et al., 2016; Yanos et al., 2007; Morrow and Weisser, 2012; Harper and Speed, 2012; Benbow et al., 2011

under-emphasis of those social factors seems to reflect the broader inadequacies in the recovery literature for understanding the role of multiple, overlapping forms of disadvantage in recovery processes and outcomes (Morrow and Weisser, 2012).

Caution is warranted when interpreting 'Table 1', however. The data derived from the mapping exercise are indicative only and may not necessarily reflect how comprehensively the social factors are addressed in those sources. To demonstrate, while concepts related to culture and ethnicity are mentioned in 31 (78%) and 20 (50%) of the sources, respectively, only ten of those are empirical studies that reported having culturally and/or ethnically diverse samples (Armour et al., 2009; Kidd et al., 2014; Kirst et al., 2014; Padgett, 2007; Padgett et al., 2008, 2013, 2016; Smith et al., 2015; Williams et al., 2015; and Zerger et al., 2014a).

Recovery in the context of socio-structural disadvantage: Gaps in theorising

A critical examination of the recovery phenomenon in the context of socio-structural disadvantage illuminates crucial theoretical, ethical and methodological inadequacies of the bulk of the recovery scholarship (Harper and Speed, 2012; Morrow and Weisser, 2012). Informed by sociological, critical theory, critical psychiatry and health inequalities perspectives, researchers have critiqued some of the fundamental assumptions of both what recovery is and how recovery should be researched (Harper and Speed, 2012; Morrow and Weisser, 2012). Specifically, there has been a tendency of the majority of research into recovery to downplay or neglect the complexities of attaining recovery in the context of poverty, homelessness, discrimination and other forms of health and social inequalities. This has led to an underproblematisation of how core recovery processes (such as hope, identity-building and meaning-making) are enabled or constrained as a result of the confluence of individual, biographical, interactional, socio-structural and socio-cultural factors (Pilgrim, 2008).

Woods et al. (2019) advance this argument by stating that as a result of '[. . .] abstracting the individual from their immediate social network and wider social context' (p. 170), it has become unclear how mental health is affected by the plethora of social, cultural and affective influences relevant to individuals' lives. This, in turn, has impeded the progress towards understanding how individuals can be optimally supported and empowered in realising their recovery in their communities. Moreover, according to Woods et al. (2019), the lack of critical structural analysis of the contexts in which recovery narratives are produced is a barrier to achieving the emancipatory and empowerment goals of the recovery movement. Understanding the intricate ways in which different forms of inequality and discrimination intersect to impact people's experience of recovery is a social justice imperative (Burns, 2009). In addition to examining the pathways that create and perpetuate disadvantage, researchers should unravel how individuals exercise and sustain their autonomy, independence and choice, their full personhood, in the face of adversity, and the implications thereof for achieving optimal health and well-being (Burns, 2009).

The tendency of recovery research to decontextualise and over-individualise recovery has been accompanied by the common under-representation of individuals experiencing one or more forms of socio-structural disadvantage. One example is the CHIME framework of personal recovery – a product of a systematic review and a narrative synthesis of

characteristics and models of personal recovery according to which there are five core groups of processes constituting recovery – connectedness; hope and optimism; identity; meaning in life; and empowerment (Leamy et al., 2011). The framework gives little consideration to the socio-economic status or other pertinent social locations that individuals with lived experience may be occupying and that may be systematically privileging or disadvantaging their abilities to recover (Leamy et al., 2011). For instance, only six of the 87 papers synthesised by Leamy et al. (2011) in their development of the CHIME framework were conducted with Black and minority ethnic (BME) participants. The authors recognise the under-representation of minority ethnic groups in the Western recovery literature and highlight examples of themes – particularly spirituality, stigma and culturally specific notions of mental health – that may be more prominent amongst ethnic minority persons (Leamy et al., 2011).

In addition, from 45 narrative studies and 629 first-person accounts reviewed by Llewellyn-Beardsley et al. (2019), only 17% represented accounts from BME participants. Moreover, 71% of those studies were conducted in the U.S. or the U.K. (of which only two – in Scotland). This arguably reflects the underrepresentation of diverse geographical and ethnic groups in the recovery literature (Armour et al., 2009). Even scarcer have been empirical studies aiming to analyse how relevant categories of difference (ethnicity, race, gender, health status, socio-economic status) intersect to shape the recovery process (Armour et al., 2009; Morrow and Malcoe, 2017). This (implicit) aversion to diversity and intersectionality in much of the recovery literature is also evident in the relatively few qualitative recovery studies adequately addressing the political, institutional, socio-cultural and systemic dimensions of narrators' experiences (Llewellyn-Beardsley et al., 2019). The authors conclude that: '[. . .] there was little discussion within analysis of how multiple forms of structural oppression can intersect and be mutually reinforcing.' (p. 23).

In contrast, Armour et al. (2009) and Zerger et al. (2014a) specifically examine ethnic minority individuals' experiences of recovery and the structural barriers to its achievement. Central to those studies' contributions to the recovery literature is their examination of how those individuals navigate multiple identities and the power differentials that systematically hinder their access to recovery-promoting capital–material and symbolic. In light of extant research on race, stress and mental health (Williams, 2018), those studies warrant further research efforts to explore the facilitators and hinderers of recovery in culturally and ethno-racially diverse groups.

Furthermore, socio-structural factors such as financial insecurity, poverty and other forms of social marginalisation have been largely neglected themes in the conceptual development of personal recovery (Stuart et al., 2017; Tew et al., 2012; Topor et al., 2011). Relatedly, Rose (2014) notes that recovery research has shown a tendency to overrepresent individuals considered 'recovered' and has therefore neglected the unique experiences of individuals 'who continue to struggle' (p. 128). Over-privileging 'mental health success stories' and narrowly defining service-users as 'successful' and 'unsuccessful' in their recovery may inadvertently contribute to the misrecognition and 'silencing' of those who may face the most severe structural barriers to recovery (Fisher and Freshwater, 2014; Jensen and Wadkins, 2007: 325).

In a recent systematic review and best-fit framework synthesis of qualitative literature on personal recovery, Stuart et al. (2017) assessed the extent to which the five core

components of CHIME were reflective of the qualitative themes featured in 12 peer-reviewed studies on recovery. The authors found that while CHIME was a generally acceptable model of recovery, it failed to incorporate the themes of financial difficulties, socio-economic disempowerment and ambiguity and contradiction in the recovery process. Accordingly, the authors conclude that CHIME may have underrepresented people who face considerable life challenges that may prevent them from recovering. Citing Onken et al. (2007), Stuart et al. (2017) posit that by focusing exclusively on individuals who self-identify as being 'in recovery' or 'recovered', researchers may inadvertently reinforce the unsubstantiated claim that '[. . .] recovery is something achievable by everyone who simply applies themselves' (p. 11). This proposition, in turn, may contribute to the harmful discourse that individuals who may struggle with their recovery are '[. . .] not trying hard enough' – eventually leading to the marginalisation of those individuals (Stuart et al., 2017: 11).

The extent to which popular conceptual frameworks of personal recovery (such as CHIME; Leamy et al., 2011) are capable of adequately capturing the processual and contextual nature of personal recovery, especially in the context of major life transitions such as homelessness and rehousing, remains contested. While Leamy et al. (2011) label the five CHIME components as recovery processes, those components reflect abstract, second-order categories that are stripped of their 'vital contextual features' (Hopper, 2007, p. 871). Furthermore, while Leamy et al. (2011) propose a transtheoretical model of change adapted to the recovery process, those 'recovery stages' remain glaringly individualistic (cognitive-behavioural) and de-contextualised in nature (e.g. 'learning'; 'determination'; 'awareness'; 'efforts'; 'self-esteem'; 'believing'). As a result, Duff (2016) argues, it has been less clear how the five CHIME components are '[. . .] enabled or inhibited within a broader web of social, political and economic contexts' (p. 62). According to Duff, uncertainty persists as to '[. . .] what connectedness, hope, and empowerment feel like for individuals living with mental illness; how these qualities are cultivated, nurtured and restored [. . .]' (p. 62).

Morrow and Weisser (2012), Pilgrim (2008) and other critics challenge the dominant individualistic and intrapsychic conceptualisation of the recovery phenomenon as one that neglects the role of the adverse socio-structural forces, such as the operation of power in society and within the mental health systems, that engender and perpetuate the distress and suffering associated with mental illness. As Bonney and Stickley (2008) perceptively note: 'Whatever the rhetoric regarding individualized care, the recovering person continues to find himself or herself cared for within rigid systems' (p. 149). Furthermore, Morrow and Weisser (2012) posit that there has been an inadequate focus on the overlapping and intersectional nature of multiple disadvantage in mental health research and on the complex relationship between inequalities and recovery. Morrow and Weisser (2012) argue that, in the recovery literature, social inequalities are rarely mentioned, and where mentioned, race, ethnicity, immigration and culture have been privileged above other types of inequalities such as those related to disability, age, sexual orientation, housing and poverty. Proponents of critical social justice theorising argue that empirical inquiries of recovery should be indivisible from the structural analysis of the durable political, socio-economic and socio-cultural forces impeding those individuals' recovery capabilities (Morrow and Malcoe, 2017). Recognising the intersectionalities of influence upon the

recovery process, particularly the influences rooted in institutional and other socio-structural arrangements, is likely to better equip researchers in unravelling how recovery happens, why, for whom and under what conditions (Harper and Speed, 2012).

Alternative frameworks for understanding recovery

While several sources critique reductionist models such as the biomedical model (e.g. Burns, 2009; Clifton et al., 2013; Fisher and Freshwater, 2014; Harper and Speed, 2012; Llewellyn-Beardsley et al., 2019; Woods et al., 2019), few offer alternative models or frameworks for studying recovery. Several tentative attempts to advance the notion of recovery by proposing alternative conceptualisations or conceptual frameworks were noted among the included works. Examples include Padgett et al.'s (2016) concept of complex recovery (discussed below); Duff's (2016) 'atmospheric conception of recovery', which incorporates a consideration of 'social and political dimensions' (p. 59); Williams et al.'s (2015) biopsychosociopolitical framework; Topor et al.'s (2011) structural recovery; and Morrow and Weisser's (2012) call for 'an intersectional social justice analysis of recovery' (p. 28). In addition, one source, Yanos et al. (2007), puts forward a model for examining the roles of structure and agency in recovery. While the majority of the aforementioned conceptual innovations remain rather under-developed, they hold potential for stimulating theoretical advancement in the field.

Socio-structural and normative constraints on mental well-being and recovery

A relatively small corpus of qualitative mental health recovery research has indeed attended to, analytically and theoretically, the socio-structural conditions within which individuals exercise their recovery (e.g. Benbow et al., 2011; Kidd et al., 2014; Lafrance and Stoppard, 2006; Padgett et al., 2016). To varying extents, those studies have attempted to account for how 'macro-socio-cultural forces' influence what is often constructed as the 'subjective, individualized process' of recovery (Livingston and Boyd, 2010: 2151; Yanos et al., 2007). Among the investigated socio-structural forces shaping recovery have been the normalised, institutionalised discourses of recovery (Fullagar and O'Brien, 2014; O'Brien, 2012); cultural constructions of womanhood and motherhood (Benbow et al., 2011; Lafrance and Stoppard, 2006; O'Brien, 2012); social discrimination on the basis of race (Armour et al., 2009; Zerger et al., 2014a); poverty, homelessness and adverse life experiences (Benbow et al., 2011; Kidd et al., 2014; Padgett et al., 2016), and others. Informed by feminist, constructionist, intersectionality and other critical epistemologies, some of those studies have aptly re-conceptualised recovery as an intersectional experience occurring amidst multiple inequalities, discourses, systems of power, norms and social practices (Lafrance and Stoppard, 2006; O'Brien, 2012).

O'Brien (2012), for instance, interviewed 31 mid-life Australian women who self-identified as 'recovered' or 'in recovery' in attempts to understand how those individuals understood and negotiated their recovery journeys within neoliberal and largely biomedical institutional discourses. Informed by Foucauldian and feminist perspectives, the author's qualitative analysis revealed that the women's narratives indicated an understanding of

recovery as the elimination of symptoms and the return to an idealised version of the productive citizen. The author named those personal constructions, 'a static notion of normalized recovery' (p. 576). The inability to achieve those normative 'targets', a major theme in the participants' accounts, was associated with fear, distress and a sense of inadequacy. Even participants who had self-reportedly made considerable progress in their recovery journey described their recovery as transient and fragile. To some of the participants, a relapse meant a failure to achieve a state of 'recovered subjectivity' (p. 576). Those recovery subjectivities denote the participants' internalised discourses regarding what constitutes normality, productivity and a successful treatment outcome.

Those women also expressed concerns about their ability to re-assume control over their lives due to the financial, occupational and marital challenges that they faced. Furthermore, O'Brien (2012) interpreted some of the women's use of various quantifiers (e.g. '99% fully recovered'; 'eight out of ten') to characterise their recovery progress as indicating an internalised view of recovery as a quantifiable, linear progression, therefore reflecting contemporary neoliberal policy discourses. One problematic consequence of such an internalised construction of recovery is the equation of 'being completely in recovery' with being normal, and, respectively, not being fully recovered – with being abnormal, inadequate or flawed. In this qualitative investigation, O'Brien (2012) critiques the so-called recovery imperative as potentially representing a form of governmentality that seeks to impose pre-defined notions of expected recovery to the neglect of individuals' unique biography, values and goals and social positioning. This study helps illuminate the intricate relationship between the normative context, including gender relations and mental health discourses, and the intimate processes of self-understanding and self-transformation that characterise recovery.

Informed by intersectionality theory, Kidd et al.'s (2014; $N=6$) grounded theory study in the Canadian context revealed that the participants, who simultaneously occupied multiple social locations associated with structural marginalisation (due to their intersecting racialised and gendered identities), faced 'additional layers of complexity and negotiation' (p. 20) in their efforts to recover. The feelings of cultural entrapment, discrimination and the 'dialectic between multiple and conflicting identities' (p. 36) compromised the participants' resilience and often made the process of recovery non-linear, difficult and ambiguous. The challenges the participants faced with achieving a coherent identity, rebuilding a sense of self-worth and navigating the power differentials in their lives seemed to erase the boundaries between the personal and the political. Despite its limited sample size, Kidd et al.'s (2014) study illustrates the utility of conducting a structural, intersectionality-informed analysis of qualitative, including visual, data on the lived experience of mental illness.

In another intersectionality-informed qualitative investigation of the experience of mental illness, Benbow et al. (2011; $N=67$) interviewed homeless mothers with mental illness in a Canadian context. The study was original in its focus on the dialectic between structural oppression and individuals' acts of resilience, and the implications thereof for their mental well-being. As such, this study challenges the individualistic accounts of mental health and recovery that neglect the socio-structural scaffolding of individuals' identities, resilience and coping. While limited methodologically by the lack of detailed demographic information collected and the reliance on secondary data, this study yielded

valuable insights into the complex social positionalities of homeless mothers with co-occurring health problems and into how they attempted to navigate those. The findings revealed the 'complex and compounding nature of social locations as intersecting sites of discrimination' (p. 692). Specifically, their participants' accounts uncovered a unique experience of discrimination on the basis of their various social identities related to their status as socially disadvantaged mothers with mental illness. This study therefore provides a compelling testimony to the pervasive effects of racism, poverty, housing instability, interpersonal violence and other forms of oppression upon individuals' abilities to maintain their health, dignity and valued social roles.

Sociologically-informed recovery research has remained remarkably scarce (Clifton et al., 2013; Markowitz, 2015; Pilgrim and McCranie, 2013; Watson, 2012; Yanos et al., 2007). Watson's (2012; $N=60$) study is among the very few empirical investigations of the impact of structure and agency on recovery. He carried out a qualitative study with both staff and consumers at several Housing First facilities in the U.S. Watson (2012) was particularly interested in consumers' experiences with both Housing First and continuum-of-care services (the latter referring to a traditional service model that emphasises conditionality and abstinence), and their effect on recovery. Overall, Watson (2012) found that Housing First was more conducive to the consumers' sense of security, hopefulness, sense of empowerment and, ultimately, recovery. The data demonstrate the role of structural influences (denoted by the structure, organisation and philosophy of the two service models) in enabling or constraining consumer agency. For instance, Watson (2012) discusses how the rigid conditionality of the continuum-of-care model undermined the consumers' certainty about the future, which, in turn, precluded them from developing a coherent self-narrative.

Watson's (2012) findings illustrate the conceptual potential and analytic feasibility of disentangling the influences of personal agency and social structure upon the recovery process in people who are formerly homeless. His investigation is underpinned by the assumption that recovery is 'an interactive process that involves transactions between the person and his or her immediate support system, the treatment system, the community and sociopolitical and cultural variables' (p. 343, citing Loveland et al., 2005: 49–50). This understanding of the multiple social, cultural and systemic influences upon the recovery process, Watson (2012) posits, is instrumental in generating 'a strong process-oriented model of recovery' (p. 343).

Despite their methodological limitations, which compromise the transferability of the findings, the aforementioned studies reaffirm the importance of examining the role of the socio-structural context for unpacking the complexity and dynamism of recovery and coping with mental health difficulties in diverse populations. Notably, those studies deploy critical theoretical perspectives such as intersectionality and feminist and critical theories to help trace the multifaceted influences of social structure upon individual agency, identity and mental health outcomes.

Recovery and homelessness: Gaps in the knowledge base

The conceptual, theoretical and methodological critique of the bulk of recovery research presented in the preceding sections is especially pertinent to the research on individuals' experiences of co-occurring serious mental illness and homelessness. Specifically, the

experience of recovery in the context of homelessness has been both underresearched and undertheorised. Those inadequacies tend to reflect the general under-emphasis in the mental health literature on the role of structural factors such as poverty, housing insecurity and other forms of socio-economic marginality on positive mental health, coping and recovery (Harper and Speed, 2012; Karadzhov et al., 2020; Yanos et al., 2007).

While qualitative studies into the substance use recovery of persons with experiences of homelessness have been numerous (Henwood et al., 2012; Neale and Stevenson, 2015), research into those individuals' personal (mental health) recovery has been markedly scarcer (Morse, 2000). The comprehensive literature search carried out within the current critical review indicated that virtually all qualitative and mixed-method studies that explicitly addressed the relationship between homelessness and personal (mental health) recovery had been conducted with formerly homeless participants. While this body of work has produced useful findings regarding those individuals' hopes and aspirations, social relationships and integration, struggles, everyday lives and recovery journeys, it does not compensate for the scarcity of qualitative investigations with individuals who are currently homeless.

The bulk of qualitative research exploring formerly homeless persons' views and experiences of mental health recovery has been conducted with Housing First clients in settings such as New York City and Canada (Kirst et al., 2014; Padgett et al., 2016; Patterson et al., 2013; Zerger et al., 2014b). Padgett and colleagues have published a series of qualitative and mixed-method investigations exploring both the biographical narratives and everyday lives of Housing First clients with serious mental illness diagnoses in New York City (Padgett et al., 2016). The series of qualitative and mixed-method studies by Padgett and colleagues has offered invaluable insights into formerly homeless clients' experiences of ontological security as a function of attaining stable and secure housing (Padgett, 2007); experiences with social relationships and their impact on recovery (Padgett et al., 2008); the identity dynamics following permanent rehousing (Smith et al., 2015); and clients' perceptions of Housing First services (Padgett et al., 2016).

Highlighting the myriad of structural, institutional and biographical factors that can potentially impinge on homeless or formerly homeless clients' efforts to recover, Padgett et al. (2016) proposed the term 'complex recovery'. As Padgett et al. (2016) argue, complex recovery should be viewed as the 'dynamic process' of overcoming the cumulative adversity that prevents one from attaining a 'recovered life' (p. 61). Complex recovery is also '[. . .] synergistic in nature; it involves more than the additive effects of multiple problems' (p.61). Padgett et al. (2016) also emphasise the need to investigate how individual factors such as trauma, poor health and homelessness interact with supra-individual factors and contexts such as social networks and service provision to affect complex recovery. While Padgett et al.'s (2016) concerns about the problematisation of the recovery concept by reconsidering the role of a multitude of factors that shape the homelessness experience seem well justified, the authors offer limited recommendations as to how to utilise appropriate theories and other conceptual tools to expand the notion of recovery. While the authors do mention the potential utility of intersectionality theory for '[. . .] framing how individual lives are affected by multiple interacting influences' (p. 68), it remains unclear how theories such as intersectionality can adequately

incorporate individual-level and contextual and structural influences into a coherent model of mental health recovery.

Due to the focus on recovery outcomes in formerly homeless adults, this body of work (e.g. Henwood et al., 2012; Kirkpatrick and Byrne, 2009; Padgett et al., 2013; Piat et al., 2017), however, offers limited insights into the processes or mechanisms that govern whether and how recovery-relevant outcomes such as hope, social reintegration, meaningful coherence and a positive self-identity are shaped by individuals' current experiences of homelessness.

As a multi-pronged 'assault' on individuals' mental, social, psycho-emotional and existential well-being, homelessness, particularly chronic and repeat homelessness, can be suspected to severely undermine individuals' capacities to engage in recovery (Drake and Whitley, 2014; Hsieh, 2016; Karadzhov et al., 2020; Kirkpatrick and Byrne, 2009; Padgett, 2007). The insidious effects of homelessness on mental well-being and recovery warrant the critical reconsideration of how processes central to recovery, such as social connectedness, self-identity, hope and empowerment, are initiated and sustained in such conditions.

Conclusion: Advancing the recovery research agenda

This critical review offered a synthesis of pertinent conceptual critique of personal recovery research by arguing that the (implicit) assumptions about recovery evident in the reviewed literature risk succumbing to a reductionist, psychologised and hyper-individualistic conception of what can be more aptly conceived as a contextually embedded and relational phenomenon (Harper and Speed, 2012; Morrow and Weisser, 2012; Price-Robertson et al., 2017). The review discussed several influential literature reviews, as well as empirical studies, to highlight the inadequate consideration of the socio-structural factors shaping the subjective experiences and outcomes of recovery. This review argues that the reviewed recovery research has remained largely ill-equipped to unravel how the socio-structural context shapes individuals' recovery journeys. The focus on homelessness, an extreme form of socio-structural disadvantage, reinforced those critiques by evaluating the research on mental health recovery in this area.

Despite tentative attempts to put forward alternative conceptual frameworks for the study of recovery in relation to socio-structural conditions (See 'Alternative Frameworks for Understanding Recovery'), a profound limitation of the reviewed recovery literature remains the insufficient theoretical engagement with the recovery concept. As noted in Stickley and Wright's (2011b) review, which explicitly focuses on analysing the theoretical development in the field of recovery, '[t]here is very little theoretical evidence presented for recovery in mental health, which draws together the differing views and discourses' (p. 305). Specific areas for theoretical development highlighted in some of the other reviews include the need for better understanding of the link between recovery and social positioning, between recovery and social inequalities, and between recovery and humanism and its values (Stickley and Wright, 2011a). Relatedly, despite the evidence for the impact of a multitude of social and structural factors on recovery, there is a need for more research into *how* experiences of recovery are affected by discrimination and other oppressive social structures and models of service provision (Tew et al., 2012; Topor et al., 2011).

While the majority of qualitative investigations discussed above have provided detailed and insightful idiographic descriptions, representations and interpretations of recovery-relevant phenomena such as identity and sense-making, few of those empirical studies have attempted to construct a theoretically-informed *explanation* linking the social context, identity and meaning-making processes and recovery outcomes and trajectories (Yanos et al., 2007). Such a comprehensive explanation should incorporate the influences of the individual's multiple contexts (relational, institutional, socio-cultural) upon the individual's capacities for recovery (Onken et al., 2007; Tew et al., 2012).

The aim of the present critical literature review is to inform and inspire critical theoretical engagement with the personal recovery concept in future research. Such research should seek to expose the socio-structural constraints rooted in oppressive and stigmatising discourses, systems and ideologies that impede multiply marginalised individuals' efforts to exercise self-directed choices and realise their authentic, emancipatory identities (Harper and Speed, 2012; Morrow and Malcoe, 2017). Arguably, mobilising the sociological concepts of (social) *structure* and (human) *agency* can help address the explanatory (theoretical) deficit that persists in the mental health recovery literature (Noiseux et al., 2009; Stickley and Wright, 2011b). Explanatory models involving the concepts of structure and agency have the potential to advance the theorisation of recovery by providing a more comprehensive and contextualised understanding of (a) how various social structures (including social networks, institutions and policies) impede or facilitate recovery, and (b) how individuals enact their own motivations, free will, values and subjective meaning-making to respond to those structures, maintain well-being and promote recovery (Angus and Clark, 2012; Clegg, 2016).

On a theoretical level, the sociologically-informed understanding of recovery in the context of homelessness is likely to advance the knowledge of how individuals exercise their personal agency to navigate, negotiate, reproduce and/or resist health and social inequalities (Nicholls, 2010; Williams, 2003). Relatedly, Clegg (2016) argues, 'Social theory needs to wrestle with understanding the multiple determinations of the concrete by employing necessary abstraction and accounting for the unseen' (p. 501). Future theoretical endeavours should aim to advance this exploration of the complexity of contextual influences upon mental health and recovery by generating explanatory accounts linking socio-economic, cultural, political, organisational, familial and other types of effects (Bhaskar and Danermark, 2006).

Understanding how exclusionary social arrangements affect individuals' recovery, and the coping strategies that individuals deploy to negotiate those, is likely to inform anti-oppressive interventions that could eventually remove the structural constraints to human emancipation and flourishing (Houston, 2001; McNeill and Nicholas, 2019). Examining how various social structures, processes and pathways differentially affect individuals' chances to achieve recovery is likely to advance an equity-based agenda in mental health and health inequalities research (Östlin et al., 2011). Such an agenda, in turn, can directly inform policies and programmes that counteract those inequality-generating mechanisms and promote equitable access to recovery-enhancing resources.

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