UNDERSTANDING AND ELIMINATING OBSTACLES TO EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESS

BY

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Abstract

This research paper utilizes a qualitative research method which identifies and reviews a series of variables that act as barriers for individuals with mental illness in attaining and maintaining employment. Research articles regarding mental illness covered problems more responsive to support, including acute depression, anxiety disorder and schizophrenia. I adopt an interdisciplinary research process to investigate across psychology, sociology, social work, adult education, and public policy studies; an analysis was performed by way of examination normalization/social role valorization theory, medical and social model of disability, empowerment theory, liberatory tradition of adult education, and disability policy. Insight produced by this research identifies barriers into the following cross level integration levels: micro individual barriers (medications, individual economics, discrimination), meso level barriers like (Human Resource policies, health care delivery systems, social service/supports), and macro barriers (discrimination policies, economics, and cultural stereotypes of mental illness). The interdisciplinary insight produced by this research reveals casual links between the variables that erect institutionalized barriers for employment for people with mental illness. Future research should focus on exploring these links in attempts to identify a comprehensive way to address this complex issue.
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Introduction

Paid employment in society is highly valued and is regarded as a sign of strong work ethic, success, contribution, and financial freedom. Unfortunately, employment opportunities are limited for people with mental illness. People with mental illness “rank employment along with housing at the top of their list” in improving their lives (Resnick and Rosenheck 2008, p.1).

In Canada “equal employment opportunity and freedom from discrimination is a fundamental right, and constituted in the Charter of Rights and Freedoms” (Canadian Bankers Association & Roeher Institute, 2001, p. 7). Attempts to create equality have fallen short as people with mental illness continue to face barriers to employment. The definition used in this paper of ‘barriers’ is similar to the concept used by Wells et al. (2002): “factors that increase risks for [mental health] disorders, worsen their course or impact, or lead to inefficient use of health care or societal resources” (p. 658).

The purpose of my research is to answer the following question: What barriers do mentally ill people face in attaining and maintaining employment? I will adopt an interdisciplinary approach to “combine components of two or more disciplines in the search or creation of new knowledge” to identify these barriers. (Nissani, 1997, p. 201). The integration of theories from psychology, sociology, social work, adult education, and public policy studies are compared and analyzed. They reveal links between the variables that erect institutionalized barriers for employment for people with mental illness across micro, meso, and macro levels.
**Justification for an Interdisciplinary Approach**

According to Repko (2012), justification for an interdisciplinary approach requires the following criteria: 1) problem is complex, 2) more than one discipline provides insight, 3) lack in ability for one discipline to address problem comprehensively and 4) focus question is at interface of disciplines. This criterion is combined in this investigation into the barriers faced by mentally ill people in attaining and maintaining employment.

The lack of interdisciplinary understanding has worked against people with mental illness. For instance, doctors and specialists diagnose and prescribe medication to the patient and refer him or her to a psychologist for counseling and psychological support. Thereafter, social workers attempt to assist clients with support networks including agencies and support workers. Individual barriers such as medication/treatment, side effects, community and internalized stigma are often missed. Improving coordination and a greater understanding to remove barriers across these micro, meso and macro levels requires examination through an interdisciplinary lens.

**Relevant Disciplines and Literature**

A perspectival approach, which relies on each disciplines perspective (Repko, 2012) was used to identify a broad list of relevant disciplines. This was then followed with a classification approach to cross-reference these disciplines with a list of phenomena (e.g. ‘discrimination’, ‘stereotyping’, attitudes towards mental illness’, ‘normalization’, and ‘inclusion’). Szostak (2000) defines phenomena as “any identifiable entities, concrete or abstract, individual or collective….ongoing, indeed eternal, characteristics of human society” (Taylor, 2012, p. 26). The relevant disciplines for this investigation were determined to be psychology, sociology, social work, adult education, and public policy.
Developing Adequacy in each Relevant Discipline

Psychology

Psychology’s focus on individual behaviour provides insight into the impact of mental illness on the individual, including treatment. However, it does not provide information about external factors that may trigger episodes. Nor does it elucidate strategies required to support people with mental illness in employment.

Sociology

Sociology provides insight into societal norms and stigmas towards people with mental illness. A social approach to mental illness “helps to redirect analysis from the individual to social oppression,” providing analyses of the social impact of mental illness and the consequences of lack of employment (Mulvany, 2000, p.583). Employment and income are linked. Income "provides the perquisites to health, such as, shelter, food, warmth and ability to participate in society” (Raphael, 2002, p. 2). In turn, the above resources allow for greater success in attaining and maintaining employment.

Adult Education

Applied to mental illness, adult education can bridge both the training and learning gap between the employer and employee by providing awareness of mental illness and effective learning and training strategies. It can expand learning across the micro, meso and macro levels, creating awareness and community development. Additionally, it provides people with mental illness with tools to advocate and identify strategies for professional and personal well-being.
Social Work

Social work identifies the need for a variety of employment support networks and programs for individuals with mental illness, in making the transition to equal employment opportunities. It focuses on the administration level and the front line support workers in social services and can shed light on underlying issues. Therefore, “as advocates, social workers can use their skills to encourage politicians and social policy makers to adequately fund mental health programs emphasizing empowerment and psychiatric rehabilitation approaches” (Stromwall & Hurdle, 2003, p. 212).

Public Policy

Public policy can enable or thwart change for people with mental illness. Disability policy is the "outcome of complex social negotiations that pertain to changing definitions of impairment, disability, and notions about the rights and responsibilities of individuals and groups” (Jongbloed, 2003, p. 205). Consistent and efficient policies on shelter, transportation, discrimination, program and employment support can dismantle many barriers faced by people with mental illness.

Analyzing the Problem and Evaluating Disciplinary Insights

In this section, I evaluate theories from each relevant discipline to explain barriers for people with mental illness.

Normalcy/Social role valorization:

In sociology, the term normalization was used in order to "enable, establish and/or maintain valued social roles for people” (Wolfsburger and Tullman, as cited in Yates, Dyson & Hiles 2008, p. 250). It is now used to describe the actions and ideas that are
considered ‘normal.’ The idea of normalization or the ‘normal’ created a binary construction of ‘normal’ versus ‘abnormal’ which has contributed to the negative stereotypes associated with mental illness.

In return, stigma occurs. People with mental illness are categorized and discriminated against. According to Erving Goffman (Davis, 2006), society categorizes people according to the "attributes felt to be ordinary and natural for members of each of these categories” (p. 131). These categorizations create stigma, and Goffman identifies two types as highlighting the “…blemishes of individual character perceived as weak will....and dishonesty, these being inferred from a known record of, for example, mental disorder,...and unemployment” (Davis, 132).

Medical Model of disability

In psychology, the medical model defines individuals by their illness or disability. It blames and finds fault within the individual for having a disability. The medical model “conceptualizes disability as the attribute of a person who is functionally limited and biologically inferior (Jongbloed, 2003, p.205). It also underestimates the social aspect of disability and assumes treatment can reduce the ‘problem’ in the individual.

Social Model of disability

Community advocates calling for the de-medicalization of services initiated a paradigm shift from the medical model, to the social model of disability. This caused disability to be viewed as a product of "economic, social, environmental barriers, and discriminatory attitudes of our society” (Grove, 1999, p.133). The social model of disability seeks to enable people to make choices and influence decisions. It also “mandates barrier removal, anti-discrimination
legislation, and other responses to social oppression” (Davis, 2006, p.199). However, the impact of the disability on the individual is neglected. This assumption of social oppression creates difficulty in distinguishing between the impact of the disability and the impact of social barriers.

Theory-Based Insights of Social Work

Empowerment:

The empowerment approach makes connections between social and economic injustice and individual barriers. The empowerment approach offers a “unifying framework” that “presents an integrative, holistic approach to meeting the needs of members of oppressed groups” (Lee, 2001, p. 160). It also recognizes that people have the capacity to critically analyze conditions of injustice and then discover and build upon their own strengths and resources to affect change. Secondly, it "links a sense of self-efficacy with critical consciousness and effective action" (p. 162). Finally, empowerment theory informs the role of social work and the process of change by enabling people with mental illness to advocate for change, and dismantle barriers.

Liberatory Tradition of adult education

The liberatory tradition of adult education encourages “us to act in support of each other to remove barriers to our individual and collective freedom…and act to change our social realities” (Bratton, Mills, Pyrch & Sawchuk, 2008, p.137). Workplace learning goes broader than where one simply has a job; “it extends into respecting social, political, economic and cultural needs” (p.161). This provides human resources departments and unions an opportunity to support both employers and employees in learning about mental illness. It promotes wellness by fostering an employee’s ability to create an identity, meaning and purpose within their work.
This empowerment bridges success in work efficiency, knowledge and personal growth including confidence and mental well-being.

Disability Policy

According to Townsend, “(t)he way in which an issue is viewed contains an implicit prescription for policy” (Jongbloed 2003: p.203). In Canada, disability policies form part of general social policies. The shift from viewing disability as a medical deficit to a sociopolitical issue has been greatly reflected in the development of disability policies (p.203). Nevertheless, negative views and stereotypes have not altered. For instance, many policies view that an inability to work is an individual issue, and view people as completely disabled or completely abled (p. 207).

Identifying Conflicts between Insights and Locating Their Sources

Conflicting Disciplinary Perspectives

Conflict arises at the general level of disciplinary perspectives of each theory. Psychology primarily focuses on individual behaviour; it views mental illness as an individual barrier, creating the binary construction of ‘normal’ versus ‘abnormal.’ This perspective conflicts with sociology that redirects analysis from the individual to focus on social oppression. In contrast, social work conflicts with both psychology and sociology as it aims to improve the quality of life and wellbeing of individuals, groups, and communities. Social work addresses both individual and environmental barriers by intervening through research, policy and crisis intervention. Other tools of intervention include community organizing, direct practice, and teaching (Fook, 2003).
At its core, adult education translates knowledge into action. It conflicts with psychology because it encourages “direct and active involvement in collective and democratic action” (Bratton, Mills, Pyrch & Sawchuk, 2008, p. 141). Furthermore, it contrasts the expert and patient role as displayed in psychology. It views mental illness as both a personal and societal barrier. In this sense, treatment comes in the form of providing access to education and awareness about mental illness to eliminate barriers. Conversely, psychology seeks treatment to eliminate barriers.

Adult education conflicts with sociology, social work, and public policy. Without a common understanding of the barriers that face people with mental illness, guidance for a curriculum poses a challenge.

Societal values “and ways of conceptualizing issues shape policies…and reflect the values of that time” (Jongbloed, 2003, p.207). However, one policy paradigm never completely replaces another. Rather, policies based on different views of disability often coexist, and often clash. Disability is “multidimensional; it is associated with medical and economic challenges, and related with issues of discrimination” (p.207). Psychology, sociology, and social work focus on particular dimensions of disability. Each discipline emphasizes certain goals and societal responsibilities that guide public policies. These disciplines conflict with public policy because they contribute to fragmented policies towards people with mental illness. Adult education acts as a vehicle to exchange information and knowledge to support social change. It conflicts with public policy as tool for distribution of information, because it fails to address a comprehensive understanding of all the variables involved that create barriers.

The second source of conflict is the assumptions that underlie each discipline, contributing to the failure in identifying and addressing barriers for people with mental illness in
employment. Psychology assumes that human behavior can be controlled and understood through a person’s mental constructs. It ignores the role that medication/treatment and social environment has on behaviour. It also overlooks the barrier that these variables cause for employment. In contrast, sociology assumes that human behaviour is influenced by social factors and ignores the impact of the mental illness.

Adult education assumes that learning is a “continuum and the pendulum is in favor of a learner-centered approach.” It assumes that interest for learning is intrinsic (Bratton, Mills, Pyrch & Sawchuk, 2008, p.140). An underlying assumption of social work is the importance of human relationships in effecting a person’s problems. Assumptions from both disciplines conflict in working together to address barriers for people with mental illness. As they rely on a person's internal motivation and desire to participate and engage in learning and relationship based interaction. In contrast to sociology and psychology, social work takes into account both the internal and external factors that may affect behavior.

Public policy assumes that behavior can be influenced to support policy goals through the following: “(1) the promotion by government officials, (2) association with positive symbols, labels, images, and events” (Schneider & Ingram, 1990, p. 519). This conflicts with all of the above disciplines because public policy assumes that it can “get people to do things that they might not have done otherwise” (523). Emphasis is solely based on changing behavior, and fails to address underlying personal and community barriers.

A third source of conflict is between the theory-based insights of each discipline. The medical model attempts to ‘fix’ the disability and also views mental illness as an individual problem. In contrast, the term normalcy/social role volarization creates stigma, sets expectations
and particular social attitudes towards people it labels, and highlights the social construct of stigma. Similarly, the social model views barriers of mental illness as environmentally and socially constructed. However, it distinguishes itself from normalcy/social role valorization because it calls for action against social oppression.

Empowerment makes connections between social and economic injustice. It enables people with mental illness to advocate for change and dismantle barriers. Similarly, the liberatory tradition of adult education calls for partnership to remove barriers. It also promotes learning to go beyond “the work site, and extend into social, political, economic and cultural needs” to educate and inform people about mental illness. (Bratton, Mills, Pyrch & Sawchuk, 2008, p. 161). Both empowerment and the liberatory tradition conflict with the normalization/role valorization theory, medical and social model. As they both focus on the relationship between the environment and individual variables in identifying and addressing barriers. Conflicting disciplinary theories create fragmented policies as each views both the barriers and methods of addressing them differently. Since the understanding of these barriers are "not conceptually linked, no one model can be used as the basis for disability policy development"(Jongbloed, 2003, p.207).

Creating Common Ground

Common ground will be created using the techniques of redefinition, extension, organization, and transformation. (Repko, 2012). Concepts that will be utilized to create common ground are ‘empowerment’, ‘social hierarchy’ and ‘(de)construction’.
Empowerment

Social services, mental health professionals, employers, and public policy administrators are part of institutional inequality. This inequality encompasses insufficient resources such as housing, training, and work accommodations as well as failing to meet the needs of people with mental illness. These critical resources empower people to live independently.

The liberatory tradition of adult education and social work recognizes the importance of power and resources. Liberatory tradition enables “us to act in support of each other to remove barriers to our individual and collective freedom” (Bratton, Mills, Pyrch & Sawchuk, 2008, p. 137). It extends workplace learning to include “respecting social, political, economic and cultural needs.” The aim then is to empower people with mental illness through knowledge and community support (p.161). The theory of empowerment complements liberatory adult education as it links social and economic injustice to individual barriers. It also recognizes that power inequalities are a result of stigma about mental illness and social hierarchy.

Normalcy/social role valorization theory values social roles. According to Davis (2006), society “categorizes people and the attributes felt to be ordinary and natural for each group” (p. 131). The medical models view of mental illness as an individual problem further stigmatizes people with mental illness. This leaves people with mental illness isolated and delegated to an inferior position. Research suggests “16% of employers would be uncomfortable hiring someone with a physical impairment, while 44% would be uncomfortable hiring someone who was in treatment for depression.” (McAlpine & Warner, 2001, p. 23).

This denial to equal employment rejects the right to attain resources, including social inclusion, political representation (policy’s and rights) and housing. This impedes the process of
achieving empowerment. Through the technique of extension, it is recognized that employment functions as empowerment and should be considered a right.

Disability policy is about focusing on,

“what people aspire, or could aspire, to do. Disability policy making should be, about enabling people to function in and contribute to society. It’s about addressing what individuals should be enabled to do for themselves and for others” (Fox and Willis, 1989: 3, cited from Prince, 2004, p.63).

Normalcy/social role valorization theory values social roles, categorizing people by attributes felt to be ordinary for that group. Employment mirrors societal views regulating the employment opportunities a person receives. Meaning that success at attaining and maintaining employment is based on a person’s preconceived role in society. Bratton, Mills, Prych & Sawchuk (2008) recognize that one of the aims of liberatory tradition of education is to include “respecting social, political, economic and cultural needs” (p.161). Disability policy focuses on enabling people to aspire to achieve their goals and enabling inclusion and contribution to society. In using the technique of redefinition, social role can be defined as a product of empowerment through support and use of educational and societal resources.

Social Hierarchy

Disability policy, social model and empowerment theory highlight stigma and discrimination as variables that maintain inequality and oppression of people with mental illness. This leads to a focus on social hierarchy. Particularly in organizations, where normalization creates a hierarchy of inclusion and exclusion that may lead to the isolation or exclusion of the non dominant group. Negative attitudes of society stem from the binary construction of ‘normal’
versus ‘abnormal’ leading to a mentality of ‘us’ versus ‘them’. This train of thought dehumanizes people with mental illness and creates a social barrier.

Binary construction creates then “masks social hierarchy (with those who are ‘abnormal’ at the bottom) and reinforces the stigma attached to mental illness” (Davis, 2006, p.72). It constructs a false sense of entitlement to power in the dominant group. In return, society adopts a false view of inferior attributions of individuals with mental illness. Employers are suspicious of “special treatment, and often speak about these invisible disabilities as institutionalized excuses…to receive special treatment” (Titchkosky, 2006, p. 130). The previous is an example of a lack of knowledge about the illness and the view that people with mental illness are a burden. It demonstrates the effects of stigma as it characterizes those with mental illness as weak and dishonest. As a result further placing blame on the individual.

Both the medical model and the normalcy/social role valorization theory reveal that social hierarchy is also based on the perceptions of individuals. This contributes to a viscous cycle of discrimination in the form of unemployment and social exclusion. It calls into question the abilities, trust and integrity of people with mental illness; enabling the allocation of empowerment to the dominant group. The liberatory tradition of adult education, social model and social work provide a platform to address social hierarchy.

(De) construction

The social and medical model of disability is based on a false dichotomy between biological impairments and social limitations. In addition, “disability is no less socially constructed than the barriers faced by people it classifies” (Schizophrenia Society of Canada,
Both liberatory adult education and social work identify education and partnership as key in reducing barriers.

Empowerment theory identifies the need for the deconstruction of disability, because social hierarchy is masked by binary construction. The medical model of disability and normalcy/social role valorization theory create the relationship of external and internal barriers that people with mental illness face. Through this, stigma and isolation is experienced from society and then internalized by people with mental illness. Their rejection reflects the public’s conception of mental illness.

Disability policy has inherent problems that exist as a result of the construction of disability. These problems stem from the following. First, the construction of disability as a 'problem'; secondly, binary construction institutionalizes social hierarchy; third, the inequality of power favors the dominant group and their negative ideologies of mental illness. The ‘problem’ is not the person with mental illness, but rather binary construction and social hierarchy that influence the public’s view of people with mental illness. The above variables create barriers for people with mental illness in attaining and maintaining employment. Through the technique of transformation, these variables can be represented by the term community development.

**Integrating Insights**

Empowerment, social hierarchy and the (de)construction of disability surfaced as common ground across all theories. I will use cross level integration described by Henry and Bracy (2012) to illustrate the interrelationship between these three variables. An analysis will cut across the micro, meso and micro levels. The micro level consists of medications/treatment,
individual economics, and discrimination. The meso-level includes human resource policies, health care delivery systems, and social service/supports. The macro level includes discrimination policies, economics, and cultural stereotypes of mental illness.

At the Micro level, according to Marwaha and Johnson (2005) for people with psychosis, keeping track of symptoms and medication is a significant barrier in maintaining employment. Both pharmacological and psychological treatment interventions can produce barriers. For instance, “the known side effects of anti-psychotic, anti-depressant, and mood stabilizing medications...can create difficulties for the provision of vocational assistance.” (Waghorn & Lloyd, 2005, p. 25). Work scheduling and accommodations around treatment can also become challenging. Additional barriers include unpredictable sleeping patterns, fear of failure, relapse, and lack of confidence (p. 29). The allocation of power was found to be a common variable across theories. The professional holds the power in this case, and the person with mental illness is demoted to the role of follower. An important aspect of removing barriers is the ability to identify and advocate for change. Without a sense of power, lack of confidence and support this task becomes very difficult.

Mallick, Reeves, and Dellario (Waghorn and Lloyds, 2005) found that both financial and employment resources presented the greatest barriers at the micro level. Financial resources include money to meet “obligations such as rent, food, and other daily expenses”(p. 29) Stigma from the community also poses a barrier to employment. A lack of knowledge about mental illness results in the community not understanding its impact on the individual. As a result “misperceptions and prejudices about their abilities and needs” creates ideologies that people with mental illness are not fit to work (p.25). Members of the community withhold opportunities
related to housing, work and community inclusion. The technique of extension recognized that employment functions as empowerment, and should be considered a right. Therefore, taking away the right to employment, takes away a person’s right to resources such as food, shelter, and inclusion.

Stigma at the meso level is magnified by negative attitudes among health care providers. They want to fix the problem in the individual. People with mental illness are viewed for the most part as unemployable. Inadequate training of staff to support people with depression, anxiety or schizophrenia can lead to discrimination through reluctance in "providing adequate vocational support or exclusion all together" (p.26). Murphy (1998) reported that people with a psychiatric disability experienced discrimination at work once their disability became known. This included the employer’s fear of the person, verbal abuse and belittling their ability and judgment. Individualistic and societal ideologies form stigma and binary construction that erects social hierarchy. Human resource departments have a role in creating a culture of acceptance and support. Adult education and social work practice can empower people with mental illness to advocate for change in the workplace.

At the macro level, the lack of clarity for policy makers and funding agencies need to be addressed. There is no clear understanding of the barriers faced by people with mental illness. Programs and policies that do exist have taken shape over time. Canadian disability policies are fragmented, for several reasons. For example, "first, programs developed incrementally to deal with separate demands. Second, disability policies are part of general welfare-state policies, which are also fragmented. Third, we have not satisfactorily addressed what it means to have a disability” (Jongbloed, 2003, p. 207). Emphasis must be placed on the importance of
employment, and the value of social supports. They enable access to resources in gaining and maintaining employment. Macro level barriers are characterized by the following: inconsistency, lack of policies demanding equality, respect, inclusion, and the institutionalization of social hierarchy. Deconstruction of disability is critical in addressing barriers for people with mental illness.

The barriers that people with mental illness face in employment cannot be captured by individual disciplines. Although these barriers are complex, variables across micro, meso and macro levels are integrated. Like an onion, through an interdisciplinary lens the source of these barriers can begin to be peeled back. It has been revealed that social hierarchy has embedded itself into society through the construction of disability. Binary construction reinforces its existence. The distribution of empowerment to the dominant (normal) group, casts people with mental illness at a tremendous disadvantage.

**Interdisciplinary Understanding**

I want to return to the focus question, “What barriers do mentally ill people face in attaining and maintaining employment?” This query was addressed through an interdisciplinary investigation. The process identified conflicts, found common ground, and integrated insights to reveal variables that make up these complex barriers. They are linked and integrated across micro, meso and macro levels. Conflicts across these levels illustrate individual and societal influences in identifying mental illness, and discrepancies in both identifying and addressing barriers. On the one hand, there are variables that “reduce the complex problems of disabled people to issues of medical prevention, cure or rehabilitation” (Davis, 2006, p. 199). On the
other, emphasis is placed on external variables as constructing barriers, failing to recognize the barriers posed by mental illness itself.

The question then becomes whether the disability/illness or social barriers are the challenge? To answer this question one has to examine the influential links between the variables contributing to the barriers. The common ground found to be among all the disciplines and their insights were empowerment, social hierarchy, and the (de)construction of disability.

There are influential links between the variables that ties them together to create barriers. Turner (2011) states that empowerment establishes a holistic approach in supporting oppressed groups. It enables social inclusion and makes connections between social and economic injustice. It does this by enabling people to recognize power inequalities. In contrast, binary construction creates and reinforces social hierarchy through 'normal' versus 'abnormal'. Therefore, power remains in the hands of the dominant group. Both societal and individual ideologies create stigma that erect barriers across a person’s life at all levels: micro, meso and macro. This affects access to resources such as food, shelter, transportation, community inclusion, and holistic health. It also affects a person’s ability to access empowerment, creating a vicious circle of barriers. The failure to (de)construct disability will continue unequal allocation of power and reinforce social hierarchy. This will result in a continued cycle of oppression for people with mental illness. Not having a common understanding of disability creates fragmentation and inconsistency in the policies that are meant to protect citizens; resulting in lack of trust and a feeling of abandonment. Through the technique of transformation, these issues can be confronted and addressed by community development activists aiming to empower people with mental illness to connect and support each other for positive change.
This involves addressing the issues faced by those with mental illness at all levels of life: micro, meso and macro. The challenge for future researchers is in finding new ways to explore and expose these links. Also, they need to address a variety of mental illnesses that are less responsive to support networks in order to construct a comprehensive way to address this complex issue. For “community development…is best pursued in an interdisciplinary manner” (Repko, Newell, Szostak, 2012, p. 183).
References


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