Troubling Inclusion: The Politics of Peer Work and ‘People with Lived Experience’ in Mental Health Interventions

by

Jijian Voronka

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Department of Social Justice Education, Ontario Institute for Studies in Education
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Abstract

This thesis is a study of how some mad people come to be known as ‘people with lived experience,’ an emerging identity and strategic essentialism which attempts to valorize the knowledge of those with experiences of distress/mental health system encounters. Currently, claiming such an identity authorizes us to work professionally as peer workers within mental health research and service systems. Thus, by virtue of our ‘lived experience,’ the peer worker becomes enmeshed in the governance of ‘similar others.’

This study maps the emergence, performance, and performativity of the peer worker through the case study of the At Home/Chez Soi project (2009-2013), a national research demonstration project which both implemented services and studied their effects to learn how to best manage the ‘chronically homeless mentally ill’ in Canada. Because peer inclusion is now considered a best practice in mental health interventions, peer workers are key paraprofessionals recruited to be part of the project assemblage. Through ethnographic and interview data, I offer a critical analysis of how peer participation is mobilized and put to work within the confines of mental health governances.

By demonstrating how peers actively work to self-govern our subjectivity and subject-positions to become recognizable as peers, this work denaturalizes peer identity. I argue that peer
work is ‘bridge work.’ we work as informants to bridge the divides between respectable and degenerate bodies in order to help inform neoliberal governance. Key to this process is peer storytelling, a central way in which our experiences become commodities, consumed as recovery narratives which help maintain us as the problems that need to be fixed. The study elaborates two main conclusions that elucidate a paradox inherent to peer work. First, that our participation is conceived as useful when the target of our experiential knowledge is directed at managing abject populations. Secondly, that when we make attempts to deploy our knowledge to challenge the regimes of truth and practices that govern us, this work is troubled and managed. In this way, peers workers, through practice, learn the rules of engagement that govern our inclusion within the folds of systems of power.
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New Becomings

I’m transforming
I’m vibrating
I’m glowing
I’m flying
Look at me now
Nick Cave & the Bad Seeds, Jubilee Street, 2014

1.1 Introduction

It’s the spring of 2008, I am transitioning into a PhD program, and a few of my friends and colleagues have started paying attention to the newly formed (2007) Mental Health Commission of Canada (MHCC). What is this national commission? What is it up to? Most importantly, how will it affect us, people who have had direct contact with mental health systems? One of my colleagues, mad-identified David Reville, gets an email invitation to attend an MHCC event held at the downtown YMCA, and bumps it forward to me. He says he will not be attending, and I ask if I can go in his place. With a little negotiation, I am granted access in his stead.

I show up, and a welcoming woman with a clipboard asks for my name. I share it, and she gives me an extra-large welcome and we have a brief chit-chat about how wonderful David is. I enter into the packed room. I don’t recognize anyone, and realize that this room is filled up with mental health players that I don’t usually co-mingle with: government policy makers, research scientists, service provider executive directors. The speaker is a member of the Commission’s Board of Directors, and starts with an overview of the Commission, the work it plans to do with its ten-year mandate, the scope of its programs. His speech then shifts to “Friends and Family” – a narrative that was new to me at the time, but is now familiar. He speaks to the importance of friends and family to the mentally ill, how we are all friends and family to someone with mental illness, and thus mental illness impacts us all. Expanding on this theme, friends and family are
particularly important as early interveners, as we (after all, we are all friends and family) are usually the first to spot signs and symptoms, and should keep watch with a gentle vigilance, and encourage our loved ones to seek appropriate help (to be determined). We, as friends and family, are all implicated in taking care of mental illness.

An hour in, a little irritated by all of this friends and family talk, I put up my hand, introduce myself as from Ryerson University’s School of Disability Studies, and a mad person, and ask: where are all these mentally ill people of which you speak? It is a consumer/survivor/ex-patient social movement move, meant simply to shift the central discourse away from caregivers and back into the hands of the social movement. Everyone wholeheartedly nods, everyone familiar with this move. I am told that the MHCC is prioritizing consumer involvement as an organization. Everyone wholeheartedly nods.

Questions veer to a researcher in the audience – everyone seems to be very interested in some project that she has in the works. She fields a few questions, and then has to leave. As she makes her way through the room, numerous people try to get her attention, shake her hand, make the telephone sign with their hand – call me. As she passes me by she taps me on the shoulder and mouths ‘well done.’ As the talk breaks, a few people are super-friendly to me. This is strange, as I am usually read as less-than-exceptional in the circles I travel. Someone asks for my card – I don’t have a card. As I leave, I wonder what that was all about. As I reflect, I realize that was my first foray into being a ‘person with lived experience.’

From that one event, I am asked to consult with the Ministry of Health and Long Term Care on a project, and am asked to gather up some more people with lived experience like me. This policy advisor obviously had a box that he needed to tick – consumers, consulted. But, at that time, new to the business, the game of participation and inclusion, it was still not obvious to me. Then, I’m
asked to sit on a provincial committee – someone was at the event, and thought I’d be suitable. And lastly, the VIP researcher calls Ryerson looking for me. She asks if I’d be interested in attending a two-day workshop in July of 2008, something on mental health and homelessness that the MHCC is starting up, and I agree.

I take a long subway and bus ride to a hotel on York Mills road, and am almost late. I’m sweaty from the long heated bus ride, and excited by the fancy hotel (I had not yet grown weary of the privilege of fancy hotels and their meetings). A nice breakfast spread is laid outside of the meeting room, and I am ushered quickly inside with a welcoming from the researcher – everyone else is already seated and ready to go.

The meeting starts with introductions with a twist – introduce yourself, and as a way to get to know each other, answer a random question. Since we are all coming from disparate work locations, stakeholders brought together with the promise of this project (I still don’t know what this project is, despite the ten page background document circulated ahead of time), why don’t we introduce ourselves and speak to our very first job. Innocuous enough. Notes taken from that meeting show me trying to pay attention to who is from what and where. The large table is filled by people across disciplines: executive directors of housing and mental health service providers; researchers in the psychiatric field; high-level government employees; housing and homelessness experts; MHCC representatives. As we wade through the introductions across this long table, first jobs get attached to people: working for my father; working with horses; working on the farm. My turn: “Panhandling. And I was very good at it.” And, I was; and I am out. Short, and both sweet and bittersweet. My position solidifies at the table – not only a person with lived experience, but with homeless experience. I feel both powerful and degenerate.
The two-day meeting unfolds, and it is first made clear that the project is working from some facts already set in stone. Health Canada has funded (the amount, not yet revealed), through the MHCC, what is being called the MHCC Homeless Demonstration Project. This is exciting news for the MHCC, and means that homelessness has been added on as one of their major initiatives. This funding started April 2008, allowing for one year of planning, and the project is to launch in April 2009. There are already some givens, decisions that have been made by a few. Project design components already determined include: a multi-site, four-year research demonstration project aimed at providing policy relevant evidence about what service and system interventions best achieve housing stability and wellbeing for those who are homeless and mentally ill. The project will include five cities, each with particular subgroups of interest. The project will involve various stakeholders in a collaborative, integrated knowledge translation process. Funding will include evaluation, rent subsidies, services and system integration components. And the project will try to build service and evaluation capacity that endures after the project ends (Goering & Barker, 2008, pp. 1-2). Rules have been set.

There are also a number of project principles that are taken as given and are to guide the project: 1) That people with lived experience be central to the project; 2) That the knowledge base derived from the research project will ultimately support more effective interventions; 3) That the project build on related work to maximize the scope of the results and impact of the study; 5) That the research be ethically sound; 6) That the project endeavors knowledge exchange; 7) That the project promote collaborations and partnerships to avoid the duplication of efforts and to leverage funds; 8) That the project work with communities to ensure lasting results and buy-in; 9) That the project strives for long-term improvements in the quality of life of participants; 10) That the project and the research addresses fragmentation through improved system integration; 11) That the project must plan for sustainability of the housing and mental health services that
At the time, much of this language, with so much meaning embedded in these thrown-about terms, these regimes of practices and truth, were new to me. It becomes clearer over the two-day meeting that out of this project, homeless people will be getting housing. Second, the project wants to study a Housing First model – I had seen a documentary a number of years ago about this housing philosophy, and remember that it made me weepy. I knew little more about Housing First. And third, the project will compare how people who get Housing First do in relation to Treatment as Usual. TAU? Specifically: “The research design will be a pragmatic, multi-site field trial of the effectiveness and costs of a complex community intervention using mixed methods. This is the strongest way of testing the effectiveness of an intervention in real life conditions. It includes randomizing the participants into experimental and control conditions. The definition of the target group and the nature of the experimental condition must be common across all sites” (Goering & Barker, 2008, p. 2). This research is outside the critical discourse analysis of my comfort zone. This is a randomized controlled trial, like a pharmaceutical clinical trial – some for you, none for you, let’s see what happens.

Given these givens, there is much talk throughout the meeting about openings, opportunities, possibilities and questions, room made for imagining. What will be the five sites that will receive this intervention? Vancouver’s a must – the 2010 Vancouver Olympics, after all. And Quebec – as a national organization, we must build relationships with Quebec. What kinds of research questions will the project ask? Sample quantitative questions, such as “What is the effectiveness and cost/benefit ratio of a proven Housing First model of care in comparison to treatment as usual for unaccompanied homeless adults with severe mental illness?” Sample qualitative
questions included “How can the lived experience of participants inform the practice, service delivery and policy implications of the study? In particular what are the service supports, community supports and natural supports and coping strategies that help or hinder participants’ recovery and facilitate their integration into the community?” My post-structuralist, critical theory, Disability Studies-self rendered useless, I am taken back to undergrad sociology quantitative research methods, and strain to uncomfortably follow along with their research design. Truth, science, and objectivity have not paid me a visit in a long while.

There are questions about defining the target population – the chronically homeless mentally ill – which are at this point in the conversation of vague national crisis. There is loose conversation about who is to be considered homeless, and who is to be considered mentally ill, as well as how the project is to recruit such a large intervention sample. We break into workshops with a focus on particular questions, and reconvene, to break away into smaller groups, and then back again into large. The first day ends, and I am told that there is a dinner at the hotel in the evening. I am also given a MHCC travel reconciliation form, and told that I can be reimbursed for any travel costs I incur. Fancy. I skip the dinner and take a cab home.

The second day is much of the same, except that I skip the morning public transit ride in favour of a taxi. Had I known that it would take over a month to be reimbursed my costs, I would have done differently. The tone of the meeting in the morning is excitement: people are excited to be at the table, and my lust for adventure seems very dim compared to their enthusiasm. We talk about ‘stakeholders’ (at the time a term unfamiliar to me), and discussion turns to local and national groups, bodies that must be built to have oversight over the project and its many, many components. A national research group, a national working group, a knowledge exchange group, and I am suddenly asked whether I think that a national consumer group would be in order. I say
yes – I know that this is what I am supposed to say. I also know that the MHCC, as they came into formation a year earlier and devised their eight subcommittees, resisted and refused (to some consumer dissent) to form a consumer-only subcommittee. If not the MHCC proper, why not make up for it with this project? I say yes, you should have a national consumer group.

We break for lunch, and a warm woman chit-chats with me, and when I tell her I am about to start a PhD program, she tells me how proud she is of me. I eat as much smoked salmon as I can fit into my belly – I like to get my money’s worth – and as the group reconvenes for the afternoon session, I awkwardly realize that I fit into neither of the set breakout sessions: one for researchers, one for consultants. I ask if I am still needed, ready to go, and I am equally ready to be dismissed. I am treated kindly, thanked, given deep meaningful eye contact, and told, ‘we’ll be in touch.’ On my way out, I grab a couple of apples and those individually wrapped yogurts and put them in my big shoulder bag – old habits die hard. Once outside, I light up (after seven years smoke free, I have tentatively started again), and walk a long while until I find an available cab (pre-cell phone, pre-learning to ask the hotel concierge to call a cab for me). By the time that I get in the cab, I am ripe with July sweat and the nerves that come with being the only marked crazy at the table.

On reflection, this meeting marked the beginnings of a new becoming for me. While I was used to using my own experiences of madness as an identity politic, I had done so largely within the context of academic and social movement settings, spaces that rest on some foundational principles. These include understanding the basics of critical approaches to madness: that it is socially constructed and constituted; that normalization is the problem to be fixed; and that focus is grounded in unsettling the larger systemic and structural processes by which mad people are pathologized, processed, and rendered marginal by systems of power. Conversely, the spaces that
I had entered through these series of meetings were reading my body through different discursive fields: I was understood as a ‘person with lived experience’ of homelessness and mental illness. I knew that this felt different: I felt powerful, and marginal, in ways that were unlike that which my mad identity evoked. Different opportunities were all of a sudden presenting: access to powers from within the mental health systems that I was used to trying to work outside of and unsettle.

When I was approached to apply for the position of ‘consumer research consultant’ for the project, I seriously hesitated. What would it mean to take on this new position of ‘peer worker’: what pains, pleasures, possibilities, conditions, and limits would be involved in this new evocation? My concerns were numerous: what does it do to bring people with marginal experiences into the folds of power that have rendered them such? What does participation in mental health research and service provisions do: how does it take hold of us as people and as systems? What does this new rendering of mad and poor people as ‘people with lived experience’ and ‘peer workers’ produce us as? What kind of work can we do within such constraints? How does it implicate us as complicit when working in such systems? More than anything, I hesitated because I was worried about my own survival. How would I endure risks that I could both anticipate and not even imagine? Scared for myself more than anything, I took the risk: it was a risk worth taking. What follows is the mapping of what it means, for myself and others, to become a peer worker.

1.2 Research Questions and Methodology

This study uses genealogy as a method to ask particular questions of how inclusionary practices within mental health fields are creating new subjects, subjectivities, and conceived knowledge bases for people with experiences of distress/mental health systems encounters. Broadly, this
study asks how mental illness and the mentally ill are currently being conceived, managed, and made sense of in contemporary Canada. What diverse tactics are used to manage neoliberal intervention projects? How has inclusion become a technology of rule within nation-building projects? How is participation in mental health interventions being conceived, theorized, and implemented? Further, how are inclusionary practices making historically subjugated bodies anew as recoverable subjects? How are ‘people with lived experience’ and peer workers grappling with issues of authenticity, authority, and representational power? What are the tactics that we draw on to make ourselves recognizable as peer workers, both to ourselves and others? And as ‘experts by experience,’ how is our experiential knowledge conceived, restricted, and put to work as we become central figures in mental health assemblages? In this way, this thesis explores questions that ask how the culmination of diverse tactics have helped to position some people with experiences of distress/psychiatric system contact as informants, authorized to play a central role in managing the ‘mentally ill.’

Michel Foucault, in part through his engagement with Nietzsche’s work, proposes how to undertake genealogical studies. Heavily influenced by the possibilities of resistance as exemplified by the events of counter-culture uprisings of the 1960’s and 1970’s (including student uprisings, the anti-psychiatry movements, and attacks on penal and legal systems in the France) (Hook, 2005, p. 5), Foucault points us towards methodological practices that work against the pursuit of truth, and rather towards the possibilities of critique as a tactic of resistance (Foucault, 1984). Most empirical studies lead inquiries which “attempt to capture the exact essence of things, their purest possibilities, and their carefully protected identities; because this search assumes the existence of immobile forms that precede the external world of accident and succession” (Foucault, 1984, p. 78). In contrast, genealogy as a process of empirical inquiry works to elucidate contestations, defamiliarize and unsettle ‘common sense’ norms and values
that have come to be truths in a given space, place, and time. Thus genealogy interrupts dominant foundations of knowledge and understanding not to offer an alternative and more ‘truthful’ foundation of knowledge, but rather, as Smart concisely summarizes, to “produce an awareness of the complexity, contingency, and fragility of historical forms” (Smart as cited in Hooks, 2005, p. 76).

As a methodology, genealogy is not concerned with finding the truth through science. Rather, genealogies trace how all truths (including the truths of science) are an “unstable assemblage of faults, fissures, and heterogeneous layers that threaten the fragile inheritor from within or from underneath” (Foucault, 1984, p. 82). Genealogies offer a reorientation towards an analysis that “suspends contemporary norms of validity and meaning as it reveals their multiple conditions of formation” (Dean, 1994, p. 33). Thus, the goal of a genealogy is not to discover new truths, but rather to generate critiques which elucidate contestation, opposition, and struggle within fields of truth: the work of genealogy is to “play delegitimized knowledges against the power-effects of established social scientificity,” and to use what is generated to struggle for difference (Hooks, 2005, p. 7). Foucault uses genealogy as a method to open possibilities for change: “Let us give the term genealogy to the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today” (Foucault, 1980c, p. 83).

Thus, the goal of a genealogy is to offer counter-hegemonic critiques which bring forward different possible ways of viewing the world, ones “which feel diametrically opposed to the social, epistemological and philosophical universe that we inhabit” (Hook, 2005, p. 27). This goal of critique is tactical: genealogy is a methodology with the end goal of offering a rigorously operative and action directed political critique to allow for new ways of strategic resistance to
dominant ways of knowing, being, and embodying. As Hook notes, genealogies “break up apparent progressions of events, to fragment the cohesion of objects and to deliberately oppose comparisons of ‘necessary sameness,’” in order to make apparent inconsistencies within totalizing assumptions about material substance, essence, and/or identity (Hook, 2005, p. 11).

As Foucault crucially argues, the project of genealogy is to reorient the purpose of inquiries away from uncovering new truths towards unsettling truth:

It is not therefore via an empiricism that the genealogical project unfolds, nor even via a positivism in the ordinary sense of that term. What it does is to entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchise and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects. Genealogies are therefore not positivistic returns to a more careful or exact form of science. They are precisely anti-sciences” (Foucault 1972, p. 83).

Thus genealogies work to emancipate historical knowledges from the tyranny of science, and to position inquiries that are “capable of opposition and of struggle against the coercion of a theoretical, unitary, formal and scientific discourse. It is based on a reactivation of local knowledges – of minor knowledges, as Deleuze might call them – in opposition to the scientific hierarchisation of knowledges and the effects intrinsic to their power: this, then, is the project of these disordered and fragmentary genealogies” (Foucault, 1980c, p. 85). Hook, expanding on Foucault’s genealogical methods, notes how the objectives of genealogies are thus for the “strategic ‘making of critique’ rather than the straightforward ‘making of truth’ … Genealogical research is thus tactical rather than unconditional (or positivistic), in its relationship to ‘truth’” (Hook, 2005, p. 8).

Genealogies approach history in a way that queries the past in order to better elucidate a ‘history of the present’: our current moment in time. This allows for new possibilities for thinking, being,
and doing. Thus, “the history of morals, ideals, and metaphysical concepts, the history of the concept of liberty or of the ascetic life, as they stand for the emergence of different interpretations, they must be made to appear as events on the stage of historical processes” (Foucault, 1984, p. 86). This means undertaking studies of history that deprive “the self of the reassuring stability of life and nature” (Foucault, 1984, p.88). Foucault characterizes ‘effective histories’ to be ones which deal “with events in terms of their most unique characteristics, their most acute manifestations. An event, consequently, is not a decision, a treaty, a reign, or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation of a vocabulary turned against those who had once used it, a feeble domination that positions itself as it grows lax, the entry of a masked ‘other’” (Foucault, 1984, p. 88). In this way, the inclusion imperative in mental health services systems marks an event: of reversals, usurpations, and appropriations of power which have allowed for ‘the entry of the masked ‘other’’—as the peer worker—into the very systems of power which previously foreclosed them.

In this study, to undertake a genealogy of peer inclusion also means undertaking a genealogy of the subject: in this case, the emergence of ‘people with lived experience’ as an identity more broadly, as well as the specificities of being peer workers. To undertake a genealogy of the subject means accepting that subjects and subjectivities are never fixed, but rather always changing, in movement, as processes of becoming. To undertake a genealogy of the subject means understanding that bodies are a key component for the operation of social relations, divided, deployed, and fractured across discursive fields of power. As Foucault notes:

The body is also directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs. This political investment of the body is bound up, in accordance with complex reciprocal relations, with its economic use; it is largely as a force of production that the body is invested with relations of power and domination; but, on the other hand, its constitution as labour power is possible only if it is caught up in a
system of subjection (in which need is also a political instrument meticulously prepared, calculated and used); the body becomes a useful force only if it is both a productive body and a subjected body. (Foucault, 1977, pp. 25-26)

Because the body must be subjected in order to be productive as a site of power, it is a privileged object of analysis for genealogical study, and Foucault was “quick to appreciate the role of the body as a ground in which various procedures of power come to be rooted” (Hook, 2005, p. 18). Thus, genealogies do not approach subject formation as static throughout time, but rather explore “the constitution of the subject across history which has led us up to the modern concept of the self” (Foucault, 1993, p. 202). Studies in genealogy attend to a history which is intractably attached to the body, and towards exposing “a body totally imprinted by history and the process of history’s destruction of the body” (Foucault, 1984, p. 83). Our bodies are embodiments of history, and as inheritances they are inscribed with history as it embeds “in the nervous system, in temperament, in the digestive apparatus: it appears in faulty respiration, in improper diets, in the debilitated and prostrate bodies of those whose ancestors committed errors” (Foucault, 1984, p. 82). Thus, this study aims to map not only the subject-making, subjectivities and identities that emerge from practices of mental health inclusion, but also the imprints that they leave on our bodies.

As a genealogical undertaking, this study maps events: the slow emergence of a conflux of moments that help to re-produce novel bodies, identities, subjects and subjectivities, as well as shifts in neoliberal governing practices within the specific context of the national At Home/Chez Soi project. I use Foucault’s concept of ‘eventalization’ as a procedure of analysis to re/discover the “connections, encounters, supports, blockages, plays of force, strategies and so on which at a given moment establish what subsequently counts as being self-evident, universal, and necessary. In this sense one is indeed effecting a sort of multiplication or pluralization of causes”
(Foucault, 1991, p. 76). To analyse inclusionary practices as events means to denaturalize our current moment in participatory mental health ‘best practices,’ to breach this event as natural, progressive, and moral/ethical, and rather to make “visible a singularity at places where there is a temptation to invoke a historical constant, an immediate anthropological trait, or an obviousness which imposes itself uniformly on all” (Foucault, 1991, p. 76). Just as “it wasn’t as a matter of course that mad people came to be regarded as mentally ill” (Foucault, 1991, p. 76), nor is it a matter of course that the mad have more recently come to be understood as ‘experts by experience,’ naturalized subjects fit to work within mental health assemblages. As I elaborate in Chapter Two, I use the concept of assemblages throughout this work to point to the heterogeneous elements from both within and outside of the psy disciplines that are brought together in novel ways to manage madness. In particular, under neoliberal governance, mental health assemblages draw together a diversity of expertise, discourses, stakeholders, and knowledges that seek to solve the problem of madness in new ways.

This research uses genealogy as a methodology to interrogate a number of current common sense truths that circulate and surround mental health governance: that madness as ‘mental illness’ is a scientific fact; that madness is an individual problem located in the mentally ill body; that the recent turn towards peer participation as a progressive best practice is a solution for social exclusion; that ‘people with lived experience’ are naturalized subjects and representational subjects; and that inclusion can work to rectify systemic social injustices. In Spandler’s (2007) article “From Social Exclusion to Inclusion? A Critique of the Inclusion Imperative in Mental Health,” she identifies some paradoxes inherent within mental health inclusionary practices: she argues that “the demand for social inclusion is paradoxical in that it both expresses a genuine desire to tackle the consequences of social inequality and yet at the same time could become co-opted as a modern form of moral and social governance which reproduces and legitimises the
prevailing socio-economic order. On the one hand it offers the promise of emancipation through the resolution of social exclusion and yet it simultaneously becomes another way in which the ‘mentally ill’ are subject to social, moral and economic regulation” (Spandler, 2007, p. 12).

Thus, as Spandler notes, the promise of inclusionary practices also risk producing new terms through which the ‘mentally ill’ are regulated: as bodies that are either willing/able to participate, while others fail to rise to the terms of engagements that inclusionary practices demand. This thesis traces the process by which some of us as ‘people with lived experience’ become included as peer workers, while most remain excluded (and thus producing new forms of exclusion – exclusion from participation). I also show how, when we join the project as peer workers, we inevitably become agents that work to manage abjected bodies. This study thus asks us as ‘people with lived experience’ and peer workers to consider how, in being drawn to such identities and work roles, we inherently become complicit in the project of governing others.

One question central to this thesis, then, is how we as propagators of peer involvement are implicated in sustaining essentialized notions of ‘people with lived experience’ in order to facilitate our inclusion within systems of power. Further, by selling ourselves as individual experts by experience to mental health assemblages, our usually denigrated experience becomes a commodity for exchange that we trade for authority, respectability, and financial gain. This works well within neoliberal agendas of “privatization, consumerism, fiscal restraint, privileging of the ‘free’ marketplace, and wholesale retrenchment of social services” (Morrow as cited in Menzies, LeFrançois & Reaume, 2013, p. 16). Neoliberalism works to individualize and responsibilize social problems, as well as those diagnosed as mentally ill subjects. As Spandler (2007) crucially notes, through participatory processes, “the solution to the problem of social exclusion becomes one of promoting a policy direction which stressed the inclusion of individuals,” and not changing the social contexts which sustain subjugation (Spandler, 2007, p.
5). As this study shows, there are many consequences to this, including how practices of inclusion distract from the problem of oppression by reducing subjugation to a problem of ‘exclusion,’ positing that inclusion into systems of power can solve the problem of exclusion. The inclusion/exclusion binary diverts attention from oppression: the structural and systemic ways in which power and subjugation are sustained. Further, participation in mental health systems requires a process of individualization. Social movement activism and advocacy are supplanted by the recruitment of select ‘people with lived experience,’ individual subjects who are offered inclusion based on personal experiences of distress/contact with mental health systems.

Althusser, on the formation of subjectivity, notes how “ideology ‘acts’ or ‘functions’ in such a way that it ‘recruits’ subjects among the individuals (it recruits them all), or ‘transforms’ the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police (or other) hailing: ‘Hey, you there!’” (Althusser, 1971, pp. 162-163). What are the implications when we turn around and respond to being hailed as people with lived experience and peer workers? Are we responding as neurochemical, psychosocial, or radical subjects? How does answering that hail to work under ‘people with lived experience’ and peer identities reify notions of a mentally ill self? How does our participation contribute to such notions of comprehensible subjectivities, most recently as bodies ruled by faulty brains as neuroscience continues to solidify madness as brain disorders, ordered by “the beliefs that neurochemistry underlie variations in thought, mood and behaviour, and that these can be modulated with drugs” (Rose, 2003a, p. 46).
Our hailing and response to being hailed matters: it constitutes us as peer subjects under recruitment, and at the same time, can reduce us to a singular figure, which Ahmed notes “conceals the different histories of lived embodiment which mark some bodies as stranger than others” (2000, p. 24). How are we as peer subjects implicated by responding to interpellation, as well as by working from our subject and subjectivities to actively proclaim that an incorporation of our identities can solve inter-institutional psy oppressions? This individual ‘healthification of social problems’ (Morrow, 2013, p.329) solved through representation works contrary to warnings that only a structurally informed analysis can produce substantial paradigm shifts across the field of structural oppressions (Menzies, LeFrançois & Reaume, 2013, p. 16). In troubling the use of relying on identity claims, Tam warns of how “due to the frameworks’ reliance on identity, users of intersectionality reify race and disability into entities and attributes, consistent across time and space, forgetting such discourses are often tethered together in their formation and enforcement as technologies of power” (Tam, 2013, p. 282). Specifically, at the threshold of peer participation, how does peer identification reify the mentally ill subject, and become in itself a technology of power? Crucially, I consider what deploying peer identity within dominant psy disciplines does, to elucidate critical reflections on such practice as we move forward with our participation.

To critique how peer participation takes place is not the same as to critique the premises on which participation relies. A growing wealth of scholarship on the limits of inclusion -- both the risks that we as individuals face when partaking as participators, as well as concerns of the consequences of embedding ourselves into systems that work to invite and sometimes co-opt our involvement without making substantial structural changes to systems of oppression -- have emerged as a way to speak back to the peer participatory turn. Yet what has yet to develop are strong critiques on the ways in which our active demands for participation rest on liberal notions
that essentialist identity-based inclusion and representation within dominant systems of oppression can help resolve our individual and collective oppression. We need to ensure that our participation does not simply become “a continuation of the neo-liberal goal of offering support to oppressed minorities without challenging the power and cultural position of dominant groups” (Marker, 2009, p. 36). We must tend to the disconnections within ‘the peer collective,’ question what we risk when relying on an essentialized ‘unified voice,’ and query the goals such performativity produces. In this study, I work to undermine much of the truth knowledge that currently permeates inclusionary practices in mental health fields. That is, I work to challenge the foundational ‘common sense’ premises on which inclusionary practices rest in order to unsettle the discontinuities that lie underneath participatory practices. In this way, my study seeks to build not an epistemology of truth, but rather an epistemology of critique (Hook, 2005, p. 8). Or as Foucault succinctly wrote, “knowledge is not made for understanding: it is made for cutting” (Foucault, 1984, p. 88).

1.3 Mad Studies: Knowledge is Made for Cutting

This research offers a troubling of three claims: that inclusionary practices are unquestionably good; that using experience to authorize claims to power is both necessary and sound; and that ‘people with lived experience’ and peer workers are innate and natural identities. I query what ‘people with lived experience’ and peer workers as emerging identities produce when participating in mental health research and service systems, specifically within the case study of the At Home/Chez Soi research demonstration project. This study offers an original contribution to the burgeoning field of Mad Studies, as not only a critique of the power of participation as a governing practice, but as an unsettlement of the power that peer identity harnesses when mobilized as a commodity exchanged for employment within mental health assemblages.
I choose, along with many others, to reclaim the language of madness. I identify as mad and use the language of madness strategically to demarcate my own understandings of distress and power away from the currently common discursive fields of mental illness, mental health, and biological explanations of distress. My use of the language of distress in this work acknowledges the very real struggles that some of us encounter with our madness, but lifts those troubles outside of the confines of mental health discourses. I do not negate experiences of madness (nor experiences of madness that people choose to understand as mental illness) but rather use the language of mad and madness strategically. To use madness rather than the favoured contemporary discourses that surround mental illness unsettles understandings of distress as purely a problem locked into the minds of individuals. Madness is language that intervenes: it unravels a number of taken for granted truths about who is human, what it means to be human, and dominant assumptions on normative human experiences. Further, it marks how mental illness is a relatively recent construct that has emerged within a much longer history of oppression, violent intervention, knowledge and cultural production, resistance, and revision. It situates madness as a historical, social and cultural construct, and challenges us to think about madness as relational and tethered to the “larger ‘matrix of domination’ (Hill Collins, 2000) that helps monitor and regulate those who disrupt hegemonic social relations and institutional processes” (Diamond, 2013, p. 74). In this way, by disengaging with discourses of mental health/illness, the language of madness helps to make visible the technologies of rule which aid in sustaining modern subjectification: not only psychiatric power but also systemized racism, “colonization, capitalism, heterosexism, ableism, ageism and patriarchy” (Diamond, 2013, p. 74).

The nomenclature of consumer/survivor/ex-patient and mad help some of us to self-identify and draw on language that is meant to signify our approach to both being labelled mentally ill as well
as indicate our belief systems towards what needs change. As Speed (2006) notes, these
discursive typologies work as resources for mad people to construct their own perceptions and
relations to madness. Yet most of those deemed mentally ill understand themselves as just that:
as belonging to an illness category and not necessarily enmeshed in political fields. Furthermore,
as Tam notes, “disability and by extension madness, is something we can have without
identifying as such” (Tam, 2013, p. 286). Thus, organizing identities across a categorical
sane/insane “bifold account ignores the many layers and nuances of Canadians’ engagement with
psychiatry and its allied disciplines” (Menzies, LeFrançois & Reaume, 2013, p. 14). Our
diagnoses or self-identification does not amount to a comprehensive politic, but rather sits, as
with other identity groups, across a broad spectrum. When we are pulled together to participate,
“tactical and strategic differences inevitably abound” (Menzies, LeFrançois & Reaume, 2013, p.
17), our diverse politics converge, and within this collective there is often more fractures than
there are commonalities. Yet as a categorical organizing tactic, ‘people with lived experience’
should be understood as a new strategic essentialism: the creation of a new identity category
where we are temporarily effacing such differences and essentializing and universalizing our
identities in order to bring forth a group identity in a simplified way in order to meet particular
aims.

One of the many troubles of organizing across difference under a collective experiential identity
is the problem of dissonant politics amongst this collective ‘we’ as people with lived experience,
a tension that marks all collective organizing (for more on the politics of organizing across
difference, see Smith, 2006b). ‘People with lived experience’ as a new strategic essentialism are
often assumed to hold a collective politics, or an apolitical illness. Harnessed under such a
collective to participate in mental health assemblages, our subjectivities are confined to who we
are - the mentally ill - and not to how we orient towards madness as a problematic. Thus, our
beliefs on ‘problems’ and ‘solutions’ diverge, and indeed how we ‘make sense’ of being deemed nonsensical are fractured across discursive fields. As a collective (or when rendered a collective), the discord and mess of often conflicting ideologies that we individually hold as ‘truth’ are always in operation, impact what we believe needs to be resolved, and what participation can do to enact resolution.

Identity and experience do not predicate an individual’s epistemological and ontological orientation towards any issue. Because of this, just as Disability Studies has worked to develop an explicitly critical politics of knowledge stemming for disability rights and justice activism, Mad Studies, as a field working alongside Disability Studies, has emerged to make more room for explicitly critical knowledge production. While much work has been done within the field of Disability Studies on issues of madness, and our experiences of psychiatric disabilities and how they are organized hold both similarities and differences (Beresford, 2000), Mad Studies as a growing field offers critical reflections on both the possibilities and limits of our identities and politics. It is within the fields of Disability and Mad Studies that a politics of peer participation needs to develop, drawing on past critiques of the risks of incorporation and co-optation, but moving forward to contend too with how disabled people, in our demands for inclusion, have become active agents of power enmeshed and contributing to the changes in governance within current neoliberal contexts.

Mad Studies as an ‘in/discipline’ (Ingram, 2008) can be defined “in general terms as a project of inquiry, knowledge production, and political action devoted to the critique and transcendence of psy-centred ways of thinking, behaving, relating, and being” (Menzies, LeFrançois & Reaume, 2013, p. 13). Just as Disability Studies allowed for a radical revaluation of disability in meaning, doing, and being, Mad Studies is a field which works to carve out “spaces of relative autonomy
while simultaneously taking up the many ‘communalities’ and points of intersection between parallel fields of inquiry and action” (Menzies, LeFrançois & Reaume, 2013, p. 12). Gorman describes Mad Studies as taking “social, relational, identity-based, and anti-oppression approaches to questions of mental/psychological/behavioural difference, and is articulated, in part, against an analytic of mental illness” (Gorman, 2013, p. 269).

Multi-disciplinary in practice, Mad Studies privileges the “subjectivities, embodiments, words, experiences, and aspirations of those among us whose lives have collided with the powers of institutional psychiatry” (Menzies, LeFrançois & Reaume, 2013, pp. 13-14). Crucially however, Mad Studies does not depend on a scholar’s self-identification in order to contribute to the project. Unlike ‘people with lived experience’ and peer workers, which relies on experience to authorize a subject as such, Mad Studies as a scholarly field emphasizes critical epistemological orientations over personal identity. Mad Studies is explicitly political in orientation, “an exercise in critical pedagogy – in the radical co-production, circulation, and consumption of knowledge. Following Foucault, the practitioners of Mad Studies are concerned with deploying counter-knowledge and subjugated knowledge as a strategy for contesting regimes of truth (Foucault, 1980, 1991) and ruling (Smith, 1987) about ‘mental illness’ and the psy ‘sciences’” (Menzies, LeFrançois, & Reaume, 2013, p. 14). Crucial to Mad Studies is that it not only reflects on the “paradigms of thought, to reigning systems of knowledge and communication, and to the institutional structures that embody and sustain psychiatric relations of power” (Menzies, LeFrançois & Reaume, 2013, p. 17), as well as “bridging the long-standing divide between scholarship and activism, theory and practice” (Menzies, LeFrançois & Reaume, 2013, p. 17), but ultimately that it also elucidates our own active involvements in such regimes of ruling.
Complementing Mad Studies, survivor research as a methodology has come into practice (see Faulkner, 2004). Advanced as the rise of user involvement in research emerged, survivor research is work that is explicitly “rooted in the political movement of people who have been subjected to psychiatric treatment” (Russo, 2012, p. 2). Sometimes misconstrued as tantamount to peer or user research, which is research conducted by people who identify as having lived experience of the psychiatric system, research that is survivor-led takes a more political stance, identifying itself as work that is aligned with critiques that “puts the entire psychiatric system in question, including the very premise of mental illness” (Russo, 2012, p. 3). Peer or user research, on the other hand, has politics that lie in reforming existing mental health service systems, and is qualified as such purely on identity - and not necessarily critical - politics. Edited volumes, such as Sweeny, Beresford, Faulkner, Nettle and Rose’s (2009) This is Survivor Research, outline the impetus for, politics, and practices of survivor research. Explicitly political and tied to “feminist, black and community development research committed to supporting the rights and liberation of people facing oppression and discrimination” (Rose & Beresford, 2009, pp. 3-4), survivor research draws on the agendas of the social movement in order to “contribute to the aims of the survivor movement” (Rose & Beresford, 2009, p.2). Such areas of inquiry include a focus on coercion and compulsory treatment, querying the power of psychiatric diagnosis, expanding on treatment choices, and the demands for greater citizenship (Pilgrim, 2005, pp. 19-20).

Similar to Mad Studies, survivor research emphasizes the value of the subjective knowledge that comes from lived experience: “perhaps the greatest difference between survivor and non-survivor research is the value that survivors, like some other oppressed groups, place on first-hand experience as a source of knowledge” (Rose & Beresford, 2009, p. 13). Survivor research is cited as imperative to knowledge production because “research participants will feel the researcher is more likely to understand what they are saying, better able to frame questions
appropriately, and treat service users routinely with respect in the research process” (Rose & Beresford, 2009, p. 13). In opposition to positivistic research, which understands Randomized Controlled Trials such as the At Home/Chez Soi project as the ‘gold standard’ in producing evidence, “survivor researchers, like many other researchers, have questioned the capacity of research about human beings to be objective … [and rather] argue that it is inevitably based on who we are, how we come to each other as researchers and/or the subjects of research, and the essential subjectivity of human relationships, including research relationships” (Rose & Beresford, 2009, p. 12).

This study’s analysis is grounded in Mad Studies and contributes to survivor research politics, as well as cross-disciplinary critical post-theoretical approaches. Mad Studies works to denaturalize our history of the present and attends to how socio-political, economic, and structural powers help constitute our experiences of both ourselves and the psy disciplines, as well as begins to explore how we make sense of such experiences through identity claims. Substantive feminist, post-structural, post-colonial and critical anti-racist analyses have troubled depending on static identity-based models of resistance by exploring the limits of subjecthood, subjectivity and drawing on experience to make truth claims. What is clear is how both Mad Studies and survivor research often depends on identity-positions to deploy counter-truth claims. Work challenging our entanglement and reliance on identity claims, and what they depend on and risk reproducing, has predominantly yet to develop in the fields of Mad Studies and survivor research.

While some recent Mad Studies scholarship has worked to unsettle notions of a mad collective identity by elucidating how white supremacy is supported and maintained within these movements (Diamond, 2013; Gorman, 2013; Tam, 2013), little work has drawn on post-approaches to identity that query the essentialist premises that we have harnessed and rely on in
order to propagate our interests. While our inclusionary demands on a small scale can work to redistribute wealth and power, we too are often seeking solutions for the problems of neoliberalism within it, seeking to revise ‘the truth’ with ‘our truths.’ Fabris, in his chapter “Mad Success: What Could Go Wrong when Psychiatry Employs us as ‘Peers’?” begins to question what this new peer subject-position can produce, and whether “the peer ‘movement’ [will] have any functions beyond psychiatry” (20013, p. 131). Through narrative inquiry, he explores the complex shift in rules of relating amongst people who have experienced the psychiatric system when involved in peer work. Specifically, how that relationship dyad changes when one is a paid to do peer work, while the other is an unpaid recipient of peer support and advocacy. Starting to question how being paid to be a peer alters the exchange between us allows explorations for power at play. More work that opens up room to explore critiques of the very claims that we use to substantiate our authority is needed, as “fostering progressive critique and systemic resistance within the Mad movement is paramount because it makes us, as activists, writers, and cultural producers, accountable to our politics by attuning ourselves to the varying effects of the political economy of ‘madness’” (Tam, 2013, p. 285). Tending to how we use peer identity as strategic essentialism, and the consequences of such power, is work that has yet to be charted (Spivak, 1990a).

1.4 The Research Design & Approach to Voice

To answer these questions, I use several qualitative research methods informed by my years of being immersed in the field as a peer worker: participant observation, auto-ethnography, critical discourse analysis, and in-depth qualitative interviews. The primary ethnographic method that I use is participation observation stemming from my four-year role as part-time ‘consumer research consultant’ for the MHCC’s At Home/Chez Soi project. As my work tasks accrued, the
contradictions presented by my job title, in comparison to my actual work, were immediate. While I consulted on research, advising here and writing there, I undertook little research in practice. My main role over my years of employment was to organize, manage, and support peer involvement, and to speak of the benefits of peer work as an emerging best practice. Thus, the paradox of peer work presented itself early to me: rather than being brought in to do research, drawing on my analytic training, I was instead pinned to my identity in order to foster, promote, and enable the project to position itself as community-based and inclusive of people with lived experiences of homelessness/mental illness. While my job title never changed, I began to be addressed as ‘national peer lead’ rather than my official title.

Throughout the course of the project, I took extensive field notes on feeling, being, and doing my role as I was involved in a wide-range of contexts: working to build, sustain, and manage peer-only groups; promoting peer involvement both within and outside of the project; and as often the only peer representative on operations, research, and working groups. There were a number of seminal moments and events throughout this work that I elucidate by drawing on auto-ethnographic methods and textual discourse analysis. I also use the ‘everyday’ life of being a peer worker and sustaining a peer identity to exemplify the repetitive culmination of responsibilities, tropes, and procedures that saturate these roles.

In the final months of the project (fall 2012/winter 2013), I interviewed fourteen peer workers working in five cities across Canada: Vancouver, Winnipeg, Toronto, Montreal, and Moncton. I interviewed peers when the project was almost complete to ensure that they had been immersed in their work roles and embodied peer identity for a substantial amount of time. The majority of the interviews I conducted in-person, booking time when I was in their respective cities. A few of the interviews were done over the phone. The interviews were digitally audio-recorded and
transcribed verbatim. Most interviews were two hours in length, and participants were paid for their time. I approached fifteen peer workers through email or phone call, asking if they were interested in participating. One person declined the invitation to participate. I then sent the consent form to participants, which were signed after the interviews were completed. I also offered to send a list of open interview questions ahead of our interview to participants, and some accepted this offer, while others declined. I emphasized that the interview guide was flexible: some of the participants wanted to answer all of my lead questions, while other interviewees preferred to narrate their knowledge without the script. The consent forms and interview guide are provided in the appendix.

I purposely selected participants to ensure peer workers from all five cities were interviewed, across a broad range of work roles, and for demographic diversity. I did not aim to select participants to constitute a ‘sample’ in the statistical sense. That is, I did not view those that I interviewed as offering a representational sampling of peer workers within a larger population. I kept the number of participants small, in part to assure anonymity. While ‘peer inclusion’ broadly occurred in the project, I wanted to interview peers who were deeply entrenched in the practice. Only a few dozen were full or part-time workers, and the rest were largely honorarium-based workers who consulted and advised peripherally. If I had proceeded with a larger sample, and thus interviewed most of those in full-time and part-time positions, it could be inferred that the majority of peer workers had been interviewed, and thus that most full-time and part-time workers’ narratives were to be found in this study. Most of the participants chose their own pseudonym, and the remainder I selected. Of note is that one participant chose to further obscure their identity by choosing a name not associated with their gender-identity. When asked if they preferred that I use gender pronouns that matched their pseudonym, they said yes. Thus, one of the limits of this data is that a gender analysis specific to peer workers cannot and is not
undertaken in this work. However, the site of inquiry is not primarily on what intra-group differences peer subjects experience when occupying these roles, but rather how their particular embodied standpoints elucidate findings that help inform the project of peer inclusion.

Further, in order to protect the anonymity of the participants, I am not attributing gender, race, and sexuality identities to each individual. Rather, here, I offer a generalized account of characteristics of those that I interviewed. Most of those whom I interviewed identified as female, followed by male, as well as Queer, Trans-women, and Two-spirited. Most that I interviewed identified as White, followed by Indigenous, and racialized. Half of those whom I spoke with identified as heterosexual, while the other half identified as bisexual, lesbian, homosexual, and Queer. Most people identified English as their dominant language, but also French and Bilingual.

Mindful of Butler’s work on accounts of the self (2005), I approach the interview data as unstable narratives, understanding that peers are always voicing experiences within larger prevailing regimes of truth, and that these words are fractured accounts, limited in translation and comprehensibility, and reworked through my own interpretation. After conducting the interviews, I sent the transcripts out to interviewees for review and edit, which prompted conversations with two participants who noted that they would have given different accounts now than they did at the time, one noting that he was in a ‘manic’ mood at the time of the interview, the other that an alteration in medication had made her ‘hazy.’ Madness itself, interventions enacted on it, and time and place are mediating factors that influence our voice in different moments.

I approach the narratives in this study (both my own and those of whom I interviewed) not as ‘authentic,’ narrated to me and then conveyed unfiltered through my writing. Instead, I critically
analyse peer narratives to evoke “a necessary and welcome discomfort rather than reassurance in readers, in troubling conventional qualitative, normative, power-silent and hegemonic constructions, and cherished assumptions of “lived experience”” (Grant, 2014, p. 574). Grant argues that undertaking post-structuralist qualitative accounts should move to undermine “the assumptions of essentialism and fixed categories and identities . . . This will enable re-imagining subjectivities in terms of varieties of difference, rather than the continued replication of homogenizing diagnostic or thematic categories characteristic of conventional qualitative studies” in mental health literatures (Grant, 2014, pp. 574-575). Further to this, it is not only the psy disciplines, but also our own deployment of lived experience as peers that requires post-structuralist critique, or we risk reifying comprehensions of knowable, authentic, and cohesive selves, rather than tracing our peer becomings as intractable effects and affects of power/knowledge production.

In the following chapters, expect to encounter an unfamiliar story of peer participation in mental health research and services: a shifting story, fraught with inconsistent voices, unstable successes and failures, alliances, victories, and loss. Mindful of Foucault’s work on the making of the subject, I approach my interviews with ‘peers’ as an eventalization: subjects made comprehensible as peers through both technologies of power and technologies of the self, within both the microcosm of the At Home/Chez Soi project, as well as the larger shifts to approaching madness (recovery, resistance, biomedicine) explored throughout this work that together help make ‘peers’ a tangible possibility. Those whom I interviewed as ‘peers’ are also subjects made abject across discourses of race, class, gender, sexuality, Indigeneity, ability, and so on: they are endangered bodies, working to build themselves as subjects and subjectivities to survive. To do so, we build relationally not only against sane/insane binaries, but also against and with other identity markers that produce us as difference in the social.
I move forward to show the productive possibilities, limits, and conditions of peer participation through a closer look at accounts of peer subject and subjectivity-making, storytelling, and how peer knowledge is conceived, construed, and deployed. By drawing on my own and others’ voice in the following chapters, I approach this account as “something other than a mere reflection of the real and theorize the multiple meanings, functions, and deployments of voice” in this writing (Mazzei & Jackson, 2009, p. 6). I thus specifically attend not only to commonly voiced experiences, but also to rupture and disidentification. Breaking from survivor research, I acknowledge that while the peers interviewed likely offered me a different account than if they were interviewed by non-survivor researchers, I understand this knowledge imparted as no closer to ‘truth.’ I ask and focus on narrative that sidesteps recognition and affinity, and following Lather, refuse “the liberal embrace of empathy that reduces otherness to sameness within a personalized culture,” and refute my capacity to truly know, through a shared mutuality of peer experience (Lather, 2009, p. 19). I work against ‘the beautiful fit’ towards “counter-practices of queering, disidentifying, denaturalizing and defamiliarizing: producing difference instead of sameness” that emerge within the confines of peer identity (Lather, 2009, p. 19). Instead of normative narrative accounts of peer participation as well intentioned, well deserved, or working towards improving participatory practice, I work with a layering of peer inclusion experiences towards situating “such efforts as a breaking on the hegemonies of meaning and presence that recuperate and appropriate the tragedies of others into consumption, a too-easy, too-familiar eating of the other. Against homogenous spaces of collective consensus and communication, such work is emotive, figurative, inexact, dispersed and deferred in its presentation of truth-telling towards responsibility within indeterminacy” (Lather, 2009, p. 23). To do so, I must not only map the psy complex’s power to produce some of us as mentally ill subjects worthy of
inclusion, but also our own responsibility in willfully tethering together the authority of lived experience.

1.5 The Chapters

I saw a beggar leaning on his wooden crutch, he said to me, "You must not ask for so much."
And a pretty woman leaning in her darkened door, she cried to me, "Hey, why not ask for more?"

Leonard Cohen, Bird on the Wire, 1969

I have written this study specifically with peer workers in mind, those who directly encounter the everyday complexity of participating in mental health assemblages. Many of us who have been helped, hindered, and/or harmed by mental health interventions want to work in mental health and social service fields, always to help make such systems better. We are lured by the desire to give back, to intervene on, and to disrupt. We are also lured in to become peer workers because, practically, it is one of very few paraprofessional fields which exist for us where we don’t have to hide experiences that are usually denigrated. The basic premise of peer work holds that our experiences are valuable assets that can help contribute to making systems and people better.

This study unpacks this very premise by showing just how our experiences are organized and put to work as knowledges, as narratives, and as bodies. I know that peer work is hard work: for myriad reasons that this study explores. But what is often hard for us to articulate is why it is hard work: hard to embody, hard to tell, hard to know. This ethnographic study offers a critical engagement with some of the problems that inclusionary practices invoke: unsettling sites of embodiment, subjectivity, and epistemology to challenge us to think harder about what we are asking for when we ask for inclusion; as well as what we are endangering through our participation. What I want this study to do is to push us as mad people to think on what our
inclusion is not only producing, but also sustaining: systems that require the subordination of some for the securitization of others.

What this study is not is an indictment: it is not a critique aimed at dishonouring peer workers, peer work, nor systems or organizations that champion peer work. It is meant to show that benevolence is never benign, and good intentions produce complex, haphazard, fragmented results that demand analytic attention. We struggle as peer workers: often we and others we work with understand that struggle to stem from our madness. I offer another entry point: that the struggles that arise from our inclusion are not simply situated in our madness, but rather that we are struggling against how our experiential knowledge, voice, and bodies are being pinned to discursive fields of power which constrain the work that we are able to do. Currently, we as ‘people with lived experience’ are organizing as excluded subjects who want into the project of managing the ‘crisis of mental illness.’ This, in effect, works to maintain systems of domination. We need to re-think what we are asking for when we ask for change, and how the tools that we use to enact change are often the very same tools which enable our subordination (Lorde, 2007).

In Chapter One, Theorizing the Subject: The Authority of Experience, I outline key concepts and theoretical debates that I rely on to explore the tensions of peer inclusion. I explain central Foucauldian concepts on how Truth, Power, Knowledge and the Subject are made, and draw on these framings throughout the dissertation. I then attend to key feminist and post-structuralist debates that have queried the authority of experience as an undisputable field of knowledge production, and apply this debate to the specificities of the emerging identity of ‘people with lived experience.’ I recognize ‘people with lived experience’ as a move to strategically essentialize a broad range of subjects and subjectivities, and outline the key dangers that mobilizing ‘lived experience’ as a commodity for inclusion within mental health systems of
power present. Two things are key when we are mobilized as people with lived experience: our inclusion is based on individual experience rather than collective politics, and our knowledge is oriented to ‘work down’ on subjugated bodies rather than towards ‘working up’ at dismantling structural violence.

Chapter Two, Mental Illness and Inclusion as a Technology of Rule, explores several technologies that help organize our approach to ‘mental illness’ in contemporary Canada. Through the establishment of the MHCC, I show how tactics of mental illness as a ‘national crisis’ that threatens us all, science, and the need for a broad range of experts to effectively combat the crisis now include ‘people with lived experience’ as experts in this assemblage. Specifically, I show how inclusion becomes a key technology of governance within neoliberal formations. The At Home/Chez Soi research demonstration project is a novel intervention engendered to both manage and study the problem of the ‘chronically homeless mentally ill’ in Canada. As the case study through which my mapping of peer work emerges, I show how managing social problems under neoliberal governance now requires a complex web of policy, administrative, research, economic, and mental health experts and expertise, which creates challenging environs for which peer workers must authorize their ‘expertise by experience.’ What becomes clear is that while our knowledge is rendered useful when managing project participants and fellow peers, the tensions and paradoxes of peer work are revealed when we make attempts to intervene on the aforementioned technologies that govern the project.

Chapter Three, Troubling Inclusion: The Participatory Turn in Mental Health, theoretically explores the dilemmas that inclusionary practices produce: as attempts to ‘make ethical’ systems of domination through the representation of those who are subjected by them. I engage key critiques of participatory practices by drawing on work that has been done to critique
participatory development projects. Specifically, I examine how inclusionary practices help keep systems of structural violence intact. I trace the emergence of the participatory turn in mental health in Ontario, and then review the ways in which inclusionary practices have been charted in mental health literatures. I explore two consequences of the participatory turn in mental health: Firstly, that power is conceptualized as exchanged through local and interpersonal acts, obscuring in the process the systemic and structural powers of mental health interventions. Secondly, that peer participation has become a science in need of measurement in order to provide an evidence-base for its efficacy and efficiency. In this way, peer participation has become aligned with positivistic knowledge production and must now justify its effectiveness to remain a significant component in the governance of mental illness.

In Chapter Four, Becoming Peer Subjects: Identity, Authenticity, and Difference, I unsettle notions of ‘peer identity’ to show how as peer workers, we actively work to manage our selves in order to become recognizable as peers, both to ourselves and those around us. The ‘inclusion imperative’ has made peer identity (precariously) advantageous by converting distress into a commodity that can be a marketable asset within mental health assemblages. Importantly, I show how when we become peer workers, we are inevitably transformed into informants, distinguished from those that we have been brought in to represent. Peer identity is bridge work: we must represent as both abject enough to represent the ‘chronically homeless mentally ill,’ and simultaneously respectable enough to work in professional settings. This creates troubles in authenticity, which peers actively work to manage through a variety of strategies in order to ‘pass as peer.’ Further, I show the effects of strategically essentializing under notions of a universal peer identity, and argue that differences of subordination amongst us within our collective peer body become reconciled as ‘diversity.’ Peer identity is both a transient and stable
identity: yet by embodying as peers, while we may fracture conceptions of who the ‘mentally ill’ are, we inevitably reify notions of mental illness by acting as corporeal representations of it.

In Chapter Five, Peer Storytelling: The Performance and Consumption of Recovery Narratives, I show how storytelling is central to the work that we do as peer workers. Sharing our stories of marginality and distress in our work roles enable a number of things: they make us recognizable as peers; they make the inclusion of people with lived experience within mental health assemblages visible; and they add to discourses of the nation as one which offers redemption to those abjected bodies who follow the terms of engagement of a white civil society. Crucially, we learn both implicit and explicit rules that govern the ways in which we are to voice our stories: in particular, personal narratives which follow tragedy-to-recovery trajectories are demanded, and stories that deviate from this trajectory are managed, troubled, or disregarded. Our stories are now commodities full of power: yet when absorbed by discursive fields that contribute to understandings of ‘mental illness’ and the ‘mentally ill,’ they invariably are used to help inform the project of how to best manage the problem that we pose to the nation.

In Chapter Six, The Peer Paradox: The Mind/Body Split, I elucidate just how our experiential knowledge is put to work within mental health assemblages. Importantly, I show how our knowledge is conceived as ‘useful’ embodied knowledge when we use it to manage the problem of ‘mental illness.’ Yet, when we make moves to use our experiential knowledge analytically to intervene on systems of power, our work becomes ‘useless’ knowledge that is managed, troubled, and can endanger our roles. Thus, one central condition of peer work is learning how to name trouble without getting into trouble. Further, as informants, a condition of our work is that we often must disavow our madness and perform as recovered subjects in order to maintain our positions. Ultimately, I show how our knowledge is conceived as useful when managing abject
bodies, but is troubled and mediated on when our work is directed at intervening in the technologies that govern us.
Chapter 1
Theorizing the Subject: The Authority of Experience

2.1 Introduction

This thesis is a study of how some mad people come to be known professionally as ‘people with lived experience,’ a designation that then authorizes us to work as peer workers within mental health interventions. Thus, by virtue of having experiences with distress/mental health systems, the peer worker becomes enmeshed in the governance of others like ourselves. I trace how a number of multiform tactics, including practices of inclusion, resistance, and reforms within mental health strategies of governance have recently authorized some of us with experiences of distress/mental health systems as a viable part of the assemblage. New forms of governmentality, broadly defined as the heterogeneous variety of programs, strategies, and techniques which together work to govern populations and individuals, emerge “by entering into periods of criticism and crisis, where multiple perceptions of failure coalesce, and where alternatives are proposed – for the failures of one mode of governing are opportunities for the formulation of another” (Miller & Rose, 2008, p. 17). I map a wide range of new strategies used to govern the mentally ill, and in particular the homeless mentally ill, and then turn my focus specifically to how people with lived experience within this project are being brought in as experts to help solve the problems of those like us.

This thesis maps in particular a reordering of governmentality in neoliberal times, where “neoliberal regimes have ‘rolled back’ the boundaries of the welfare state, not in order to remove power but to entrench it further at the level of the individual. They govern less through the formal institutions of the state, and more through forms of ‘expertise’ that seemingly lie beyond
it – for instance, in the ‘caring professions,’ in the media or the family – that encourage action on
the self, by the self” (Bragg, 2007, p. 345). I show that it is within this context that peer workers
have become new experts within the governance of mental illness: we model self-governance,
help others like us learn to self-manage and support, and in doing so extend our knowledge to the
assemblage. Crucially, this study shows how our expertise by experience is absorbed within
systems of governance: that our knowledge is useful in the realms of governing ourselves and
others, yet when we make moves to change, challenge, or resist the prevailing order of how
systems of power/knowledge operate, we are less successful.

In Part One of this chapter I present key Foucauldian concepts on which I rely to explore the
paradoxes and contradictions of peer work. I explain Foucauldian concepts of power/knowledge,
regimes of truth, disciplinary power, and biopower. These are key concepts that I use throughout
this thesis to understand neoliberal governmentality. I then engage theories of subject and
subjectivity-making: of how both subjects and subjectivities are made, as well as how new ones
emerge. I focus specifically on how conceptions of madness have helped to create a variety of
divergent subjects and subjectivities, in order to situate the emergence of ‘people with lived
experience’ as a viable identity, subject position and subjectivity. I explain how I use notions of
degeneracy and respectability to illustrate how particular subjects, populations, and experiences
are deemed valuable and other as a danger to civility.

In Part Two, I attend to key feminist and post-structural debates on the politics of experience and
experiential knowledge as they relate to truth telling, and use these theoretical debates to help
inform a politics on ‘people with lived experience.’ I identify some of the problems that arise
when ‘mad people’ who hold a diversity of epistemological and ontological understandings are
strategically essentialized under the rubric of ‘people with lived experience.’ I then attend to how
‘lived experience’ as an identity category rests on understanding the knowledge that is derived from experience to be situated in personal experience, rather than as socially and structurally constituted. I end by raising questions as to how we need to attend to what the emergence of ‘people with lived experience’ and ‘peer workers’ produces, and the dangers that it risks: in particular, how our knowledge is conceived as ‘useful knowledge’ when it is directed towards elucidating understandings of the marginalized, and how it is viewed as ‘useless knowledge’ when as peer workers we make attempts to use our experiential knowledge to critique/change systems of power.

2.2 Part One: Governing the Conduct of Conduct

Power relations, governmentality, the government of the self and of others, and the relationship of self to self constitute a chain, a thread, and I think it is around these notions that we should be able to connect together the question of politics and the question of ethics. (Foucault, 2005, p. 252)

Studies in governmentality offer an analysis of who can govern and who is governed, but they also trace the means by which the shaping of someone else’s activities is achieved (Mills, 2003, p. 47). Foucault initially coined the term governmentality to explore the ways in which populations were organized in modern Europe through the rise of the idea of the State. He then expanded the use of the term to also consider the techniques and practices that govern the conduct of individuals as well as whole populations. Foucault (1991) argued that governing subjects and populations require a very diffuse array of strategies that circulate through power: “Governing people is not a way to force people to do what the governor wants; it is always a versatile equilibrium, with complementary and conflicts between techniques which assure coercion and processes through which the self is constructed or modified by himself” (Foucault, 1993, pp. 203-4). Thus, governmentality attends to not only to the powers of State, but also to that of individuals, and thus governmentality should be understood as an assemblage “formed by
the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the
exercise of this very specific albeit complex form of power” to govern (Foucault, 2002, p. 211;
see also Latour, 2005).

Key to understanding how governing proceeds is being mindful that it is not only a coercive top
down process to which we submit (or don’t), but rather a complicated interplay of State, private,
social, and practices of the self which together form ways of ordering a subject “in their
relations, their links, their imbrication with those other things which are wealth, resources, means
of subsistence, the territory with its specific qualities, climate, irrigation, fertility etc.” (Foucault,
1991, p. 93). Further, governing attends to how subjects relate to “customs, habits, ways of
acting and thinking” as well as “accidents and misfortunes such as famine, epidemics, deaths,
etc.” (Foucault, 1991, p. 93). While the power of the State is still understood as central,
governmentality attends to the active processes by which we as subjects are engaged with and
attend to the making of the self, of others, the State, and of life itself. Thus, studies in
governmentality attend to “the role accorded to ‘indirect’ mechanisms for aligning economic,
social and personal conduct with socio-political objectives” (Miller & Rose, 2008, p. 26).

In this way, “instead of viewing rule in terms of a state that extends its sway throughout society
by means of a ramifying apparatus of control,” governmentality “draws attention to the diversity
of forces and groups that have, in heterogeneous ways, sought to regulate the lives of individuals
and the conditions within particular national territories in pursuit of various goals. Rather than
‘the State’ giving rise to government, the state becomes a particular form that government has
taken, and one that does not exhaust the field of calculations and interventions that constitute it”
(Miller & Rose, 2008, p. 27). Central to understanding governmentality is the way in which
power is conceptualized. While power still operates through direct domination, oppression,
exploitation, violence, and discipline, governmental power is conceptualized as circulating, diffuse, and relational. This form of power is understood as dispersed through all social relations rather than imposed from above, as unstable and in need of constant repetition and maintenance, and as productive as well as repressive, and as continually in action and activated (Mills, 2003, p. 47).

As part of his scholarship, Foucault studied neoliberal governmentality. He noted that neoliberal governmentality is a new formation that has its roots in traditional liberalism, yet with a discernable shift. In his 1978-1979 course lectures, Foucault showed how the rationality of neoliberal economies began to be used in America to govern social problems: that is, “to extend the rationality of the market, the schemes of analysis it offers and the decision-making criteria it suggests, to domains which are not exclusively or not primarily economic: the family and the birthrate, for example, or delinquency and penal policy” (Foucault, 2008, p. 323). This new way of governing populations also changed the ways in which individuals related to self. While the liberal subject is a ‘man of exchange,’ neoliberalism strives to ensure that individuals are bound to assume market-based values in all of their practices in order to become ‘entrepreneurs of themselves.’ In this way, the neoliberal subject is a “free and autonomous ‘atom’ of self-interest who is fully responsible for navigating the social realm using rational choice and cost-benefit calculation to the exclusion of all other values and interests” (Hamann, 2009, p. 38).

In this study, I show how novel neoliberal governances of ‘the chronically homeless mentally ill’ not only change the ways in which such populations are governed, but how neoliberal governances also allow for the emergence of new subjects: as ‘people with lived experience’ and peer workers. In this way, our experiences of distress/mental health systems become
commodities that we harness and exchange in order to re/join the labour force through employment roles within neoliberal mental health research and service systems.

According to Miller and Rose (2008), to undertake a project that studies governmentality means attending to questions such as

How, and to what ends, did so many socially legitimated authorities seek to interfere in the lives of individuals in sites as diverse as the school, the home, the workplace, the courtroom and the dole queue? What sort of knowledge base and knowledge claims underpinned such schemes for intervention, and were they drawn from the realms of psychological, sociological or economic theory, from other knowledge claims, or from ‘common sense’? What sorts of devices made such interventions possible, to what extent did they deploy existing instruments, and to what extent were they invented? What understandings of the people to be acted upon – whether explicit or implicit – underpinned these endeavours, and how did they shape or reshape the ways in which these individuals understood and acted on themselves? What has it meant to intervene in the lives of individuals in ‘liberal’ societies, that is societies that proclaimed the limits of the state and respect for the privacy of the individual? (p.1)

In this study, I use governmentality as a concept to explore how people with lived experience (PWLE) and those who are positioned as peer workers have come to be ‘experts by experience,’ now positioned as key players in managing both their own selves as well as the selves of similar others. That is, I am interested in their production and positioning as experts who can self-govern and govern others by shaping lives, and acting and intervening on them. Studying the emergence of PWLE and peer workers as a budding form of expertise means mapping “how such expertise has been formed, the historical emergence of the problems which seemed to call for professional ‘know-how,’” and in this study, exploring the new ways in which some ‘mentally ill’ are now recalibrated as key experts in managing their own as well as others’ mental illness (Miller & Rose, 2008, p. 12).
2.2.1 Power/Knowledge and Regimes of Truth

In order to legitimate and justify particular forms of governance, we must understand such actions as the correct way to approach and proceed with a given intervention. Much of Foucault’s work attends to the processes through which things become established as fact: that is, “the processes which led to certain facts being known rather than others” (Mills, 2003, p.68). Through the term power/knowledge, Foucault advanced that the two worked together: that “it is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power” (Foucault 1980a, p. 52). This is an important theoretical advance in how knowledge is constructed, as it emphasizes the way that knowledge is not objective but rather an integral part of struggles over power, and it also draws attention to the way that, in producing knowledge, one is also making a claim for power. For instance, in positioning people with lived experience as holders of particular forms of experiential knowledge, we position ourselves as having knowledge that others cannot, and thus this gives us new forms of power. The compounding of power/knowledge elucidates the way that these two elements depend on one another (Mills, 2003, p. 69).

Foucault understood truth as produced, productive, and contingent, as well as “produced only by virtue of multiple forms of constraint” (Foucault, 1980b, p. 131). Thus, truth here is understood as made, and one must attend to the ways in which some truths become authorized as such while others are discounted in a given time period. What Foucault calls ‘regimes of truth’ are those knowledges which become understood as truth: “Each society has its regime of truth, its ‘general politics’ of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true” (Foucault, 1980b,
Further, as Mills explains, “Foucault argues that rather than knowledge being a pure search after ‘truth,’ in fact, power operates in the processing of information which results in something being called as a ‘fact.’ For something to be considered a fact, it must be subjected to a thorough process of ratification by those in positions of authority” (2003, p. 72).

In this way, regimes of truth and power/knowledge work together to make truth, fact, and common sense knowledge in a given time. These processes are always being maintained, revised, and reiterated. The set of processes and procedures form our ‘will to truth:’ our need to continue to forge sets of knowledge that distinguish what sets of statements are considered false and what knowledge is considered true (Foucault, 1981, p. 56) which contribute to how we order and govern in particular eras. These sets “of procedures which produce knowledge and keep knowledge in circulation can be termed an ‘episteme.’ In each historical period this set of rules and conceptual tools for thinking about what counts changes” (Mills, 2003, p. 71). Thus, power/knowledge and truth are intricately connected and help us to understand how “there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (Foucault, 1977, p. 27). This study explores how new regimes of power/knowledge and truth construct madness as mental illness, and help to unpack how mentally ill subjects are suddenly positioned as holding key knowledge to help explain, support, and intervene on ‘those like us.’

2.2.2 Disciplinary Power and Biopower

Disciplinary power and biopower are two power formations that are central in understanding systems that are deployed to govern madness. In The Birth of the Clinic: An Archeology of Medical Perception (1973) Foucault shows how through the advent of the hospital, the clinical method and the medical gaze, the body is constructed. That is, the clinical model is not an
impersonal process that alienates individuality, but rather a process that produces both the ill body and the healthy body. The sick, the mad, and the deviant came to be known as subjects through the case study, and work in opposition to the normative body. The knowledge of individual histories of both body and mind as captured in the case study went on to produce the abnormal as bodies to be regulated. Once bodies were marked as such, measures are taken to control them. While overt disciplinary techniques such as imprisonment, quarantine and confinements occur, Foucault argues that disciplinary powers more often rely on self-regulation: that is, technologies of the body and the self, such as lifestyle changes, exercise, and the self-regulation of behaviours. Thus, disciplinary power is a form of surveillance which is internalized, whereby bodies marked abnormal ideally come to learn to discipline themselves (Voronka, 2003, p. 15). Foucault argued that eventually disciplinary powers could effectively train bodies to train themselves, creating self-correcting and docile bodies (Dreyfus and Rabinow, 1982, pp. 134-135). Once disciplinary power is adopted as self-discipline, the social body becomes one that can be subjected, used, transformed, and worked on, while those whom resist/refuse to self-discipline are marked as ‘problems’ to be intervened on (Voronka, 2003, p.15).

Importantly, Foucault characterized the 19th century shift towards disciplinary techniques as encompassing whole populations: everyone is made through disciplinary power. “All the authorities exercising individual control function according to a double mode; that of binary division and branding (mad/sane; dangerous/harmless; normal/abnormal); and that of coercive assignment, of differential distribution (who he is; where he must be; how he is to be characterized; how he is to be recognized; how a constant surveillance is to be exercised over him in an individual way)” (Foucault, 1977, p. 199). Through processes of population management, the social body came to be known. Foucault marks this shift in technologies of
power in *The History of Sexuality: Volume 1: An introduction*, where the State’s main role slowly became “to ensure, sustain, and multiply life, to put life in order” (Foucault, 1978, p. 138). By the nineteenth century, rights discourses proliferated, and populations came to accept and expect regulations that offered “the ‘right’ to life, to one’s body, to health to happiness, to the satisfaction of needs, and beyond all the oppressions or ‘alienations,’ the ‘right to rediscover what one is and all that one can be, this ‘right’ … was the political response to all these new procedures of power” (Foucault, 1978, p. 145).

This power that was redirected to invest in life, to discipline both individuals and populations, Foucault called bio-power. On the one hand, it is discipline which “centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the disciplines: an anatomo-politics of the human body” (Foucault, 1978, p. 139). This focus of power on the individual body works in consort with larger population management tactics. That is, “on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity … Their supervision was effected through an entire series of interventions and regulatory controls: a bio-politics of the population” (Foucault, 1978, p. 139).

Biopower operates by merging both the administration of individual bodies and the large-scale management of everyday living. Biopower as a technology transformed the ways in which individual bodies and the workings of society together come to be, know, and organize themselves. Disciplinary power and biopower work together as “knowledge/power’s two conjoint modes of functioning, though it is true that they do have their own specific foci, points
of application, finalities, and *enjeux*: the training of bodies on the one hand, and the regulation of the population on the other” (Fontana & Bertani, 2003, p. 279). Throughout this thesis I show that both the Mental Health Commission and the At Home/Chez Soi project operate as biopolitical action which work both to regulate and discipline ‘mentally ill’ individuals, as well as offer knowledge about and strategies for managing them as a population.

2.2.3 Struggling for New Subjects

The main object of these struggles is not so much to attack this or that institution of power, or group, or elite, or class but, rather, a particular technique, a form of power. This form of power is exercised on immediate everyday life, it categorizes individuals and distinguishes them through their own individuality, it attaches them to their identity, and it imposes on them a law of truth that must be recognized in them. It is a form of power which makes individuals subjects. (Foucault, 1982, p. 781)

Foucault’s body of scholarship attends not only to the governance of others through subjectification, but crucially also maps how individuals become particular kinds of subjects through makings of the self. His work elucidates “on the one hand, the biopolitical governance of populations and, on the other, the work that individuals perform upon themselves in order to become certain kinds of subjects” (Hamann, 2009, p. 38). Foucault’s work on subject formation theorizes not only that subjects are made but also constituted by focusing on how *particular* subjectivities and identities became materially possible and understandable within specific historical frameworks. In *The History of Sexuality*, he seeks to trace how within the Victorian era, discourses on sexuality were framed as unspeakable, but that technologies of subjectivity framed them as unspeakable by speaking of little other than sex. Through technologies of subjectivity, “under the authority of a language that had been carefully expurgated so that it was no longer directly named, sex was taken charge of, tracked down as it were, by a discourse that aimed to allow it no other obscurity, no respite” (Foucault, 1978, p. 20). He seeks to explore how
subjects came to know themselves as ‘sexual human beings’ through discourses that relied on categorical dividing practices that constituted both normalized sexual practices and its others.

Foucault wrestles with how it is that the Victorian era is re-membered in our history of the present as an age of sexual reserve when in actuality “the nineteenth century and our own have been rather the age of multiplication: a dispersion of sexualities, a strengthening of their disparate forms, a multiple implantation of ‘perversions.’ Our epoch has initiated sexual heterogeneities” (Foucault, 1978, p. 37). How is it that during the last two centuries we have understood ourselves to become more sexually repressive when in fact we have created, sustained, and classified desire and sex practices into a whole new industry of sexual being?

*The History of Sexuality* provides a counter-discourse to Victorian reserve by showing how, in the ongoing redefining of sexual ab/normalities, there was actually a proliferation of sex talk (much of which was how sex talk could not be talked about).¹ Foucault shows how, suddenly, subjects came into being through the sexual practices in which they partook. There was, of course, focus on sexual norms, which became stricter, but “the legitimate couple, with its regular sexuality, had a right to more discretion” (Foucault, 1978, p. 38). On the other side of the divide, what came under scrutiny “was the sexuality of children, mad men and women, and criminals; the sensuality of those who did not like the opposite sex; reveries, obsessions, petty manias, or great transports of rage. It was time for all these figures, scarcely noticed in the past, to step forward and speak, to make the difficult confession of what they were” (Foucault, 1978, pp. 38-39).

¹ For a critique of the ways this work fails to analyze race and colonial relations as dense transfer points for the making of sexuality see Stoler’s *Race and the Education of Desire: Foucault’s History of Sexuality and the Colonial Order of Things* (1995).
Experts in medicine and psychiatry began to define subjects through their sexual acts. ‘The homosexual’ became a subject made possible within this discursive Victorian moment – and since then has come to an identity (always contesting and regenerating) that has been interiorized as a defining attribute of self. There were many other ‘minor perverts’ that 19th century psychiatrists sought to identify and solidify in the body mass. “There were Kraft-Ebing’s zoophiles and zooerasts, Rohleder’s auto-monosexuals; and later, mixoscopophiles, gynecomasts, presbyophiles, sexoesthetic inverts, and dyspareunist women” (Foucault, 1978, p. 43). These possible subjectivities did not manage to hold the way that ‘homosexuality’ (or other mental illnesses put forth by the psy disciples – like the 19th century advent of schizophrenia) has. As Foucault notes, we must understand discourse as a series of discontinuous segments that come into play in various strategies. Some stay, some sway, while all are always changing. When they stay, we should question why – “on the two levels of their tactical productivity (what reciprocal effects of power and knowledge they ensure) and their strategical integration (what conjunction and what force relationship make their utilization necessary in a given episode of the various confrontations that occur)” (Foucault, 1978, p. 102).

These typologies didn’t work to contain a focus on sex, but rather worked to proliferate discourses on their possibilities: “The machinery of power that focused on this whole alien strain did not aim to suppress it, but rather to give it an analytical, visible, and permanent reality: it was implanted in bodies, slipped in beneath modes of conduct made into a principle of classification and intelligibility, established as a raison d’être and a natural order of disorder … The strategy behind this dissemination was to strew reality with them and incorporate them into the individual” (Foucault, 1978, p. 43-44). Sexual acts were transformed through technologies of subjectivity into incorporations of technologies of sex. It became a way that we make our own inner stamp of individuality. It also, of course, became a mode of biopower: a “theme of political
operations, economic interventions (through incitements to or curbs on procreation), and ideological campaigns for raising standards of morality and responsibility … Spread out from one pole to the other this technology of sex was a whole series of different tactics that combined in varying proportions the objective of disciplining the body and that of regulating populations” (Foucault, 1978, p. 146).

2.2.4 Making Subjects

Foucault’s work on subject formation has influenced the way we understand how subjects are made. A central premise of most contemporary critical theory is that subjects and subjectivities are made and made sense of through discourse. We are not ‘born this way,’ but rather through a multiplicity of ways, we come to be and continue this process of becoming through encounters (Grosz, 2005). Critical theorists have written extensively on how the processes of interpellation recruit and constitute subjects (Althusser, 1971; Fanon, 1967). Much of Foucault’s work attends to the different ways in which human beings are made into subjects: focusing on modes of objectification that work to constitute subjects: modes of inquiry that are science based (i.e. biology); the dividing practices (i.e. sane vs. mad); and the processes by which humans turn themselves into subjects (i.e. as sexual beings) (Foucault, 1982). Thus Foucault claims “it is not power, but the subject, which is the general theme of my research” (Foucault, 1982, p. 209). One of the contributions that Foucault’s work has made, as Derek Hook notes, and which many theorists have built upon, is showing what mechanisms, strategies and techniques “power uses and relies on for constituting subjects, through technologies of self and technologies of subjectivity” (2007, p. 216).

Technologies of subjectivity work on the one hand to set a broad number of heterogeneous self-regulative practices that bring the “varied ambitions of political, scientific, philanthropic and
professional authorities into alignment with the ideals … of individuals” (Hook, 2007, p. 216). Technologies of subjectivity are ways of learning self-conduct that draw on the recommended ideals of experts (we all know them: psychiatrists, teachers, social theorists, etc) in the field of subject-making. We become the ‘how to be our best’ by adopting these operations of power “that connects the norms of authorities to the motivating ideals we have of ourselves” (Hook, 2007, p. 246).

Technologies of the self, in turn, are the ways in which we are able to constitute ourselves as subjects, by drawing on the technologies of subjectivity that allow for the “operations of government to be articulated in the terms of the knowledgeable management of the human soul” (Hook, 2007: 216). Thus, technologies of self are strategies that “permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1988, p. 18). This self-governance is crucial to how we constitute ourselves as individuals – bits and bites from discursive fields come to constitute our inner world and become part of how we understand ourselves as unique and individualized beings. Together notions of technologies of subjectivity and of the self offer an understanding of the interplay between macro-structural apparatuses that influence us as well as the micro-politics of subject-making. As Hook notes in his engagement with Foucault’s work, technologies of subjectivity/self provide “an analytical means for examining that ‘go-between’ area in which deeply private, individualized (and ostensibly ‘internal’) practices of self and subjectivity are already political operations, with broader political objectives and effects that may be dispositionally linked to macro forms of state power” (Hook, 2007: 216).
In this way, processes of subject formation and self-governance expose how self-constitution and the conduct of conduct are always in/directly linked to external mechanisms of power. It also insists that “many of our most private or internalized practices of subjectivity provide a means of articulation for larger-scale political rationalities” (Hook, 2007, p. 218). This is not to say that mechanisms of power (say, the State) dictate how we constitute ourselves, as cause and effect. Rather, “it is a question of arranging things and people always towards their most profitable and productive outcomes. The logic of government is that of the ever-changing, and ever-tactical, orientation of people and things towards relations of greatest benefit” (Hook, 2007, p. 226).

For instance, with regard to peer involvement, on the one hand, in a radical politic of fighting for both systems-change and self-determination, peers use power to articulate new subjects, subjectivities and possibilities within social realms. One the other hand, while this counters the historical understanding of mad people as unable, technologies of power have been able to respond to such new assertions and incorporate them towards orientations which fit well with assertions of productivity, including getting ‘the mentally ill back to work.’ Power never works to completely determine or control how subjects are made. Foucault posits that since the 16th century, the modern state has been mistakenly “envisioned as a kind of political power which ignores individuals, looking only at the interests of the totality” (Foucault, 1982, p. 213). Foucault warns that we should never “consider the ‘modern state’ as an entity which was developed above individuals, ignoring what they are … but on the contrary as a very sophisticated structure, in which individuals would be shaped in a new form, and submitted to a set of very specific patterns” (Foucault, 1982, p. 214).

It is important to understand that this is not to propose that power operates on subject formation in a rational, pre-determined, linear, cause and effect fashion: that is, “this interchange between
structures and subjects, discourse, and subjectivization, between technological ‘protocols of being’ and the vicissitudes of identification and action cannot be reduced in this way” (Hook, 2007, p. 256). Technologies of subjectivity and their experts do not coercively dominate subjects to conform to normalizing subjectivities, and these subjectivities are not linked to any direct collusive correspondence to larger political interests. Rather, “the contradiction of freedom to be appreciated here is that ‘governments of subjectivity’ demand that ‘authorities act upon the choices, wishes, values, and conduct of the individual in an indirect manner’ …” (Rose, 1991, p. 10) There is a degree of personal freedom to such practices of the self. In those technologies of self which allow some latitude in how one experiments with, remakes, or alters the self, there is always the potential for non-normalized forms of self-regulation; hence the idea of “making oneself as a work of art” (Hook, 2007, p. 28). Indeed, the self should most often feel free to understand their selves as ‘free:’ that their interiority and inner truths are derived from them, for them. For the modern matrix of individualization to sustain itself, “it requires the free-play of their personal freedoms, the bottom-up support of their independent ‘self-makings’” (Hook, 2007, p. 243).

Indeed, (self)-governmental power relies on, and mobilizes, individual free play in subject-making. Within histories of overt and excessive micro-management of subjects, such as in apartheid states, in “the attempt to legislate, codify, to structure virtually all aspects of informal, micropolitical social life, ultimately apartheid’s racist system of power [can become] overly rigid, inflexible, less than proficient at adaptation and less than able to muster creative or spontaneous responses to challenges to its logic” (Bozzoli as cited in Hook, 2007, p. 242). The balance relies on making technologies of the self/subjectivity into programs of action that are integrated into ‘structures of feeling and doing’ that produce subjectivities (race, sanity, gender

Further, that which is naturalized always has the ability to be brought to light and queried as constructed – and it is here where subjectivities come into question, are disrupted, and are reorganized into something different. This individual struggle to self is a process that differs greatly from grand external struggles of resistance (revolutions, class struggles, liberation movements). Foucault characterizes struggles to subjecthood as immediate, ‘anarchistic’ ones:

They are struggles which question the status of the individual: on the one hand, they assert the right to be different and they underline everything which makes individuals truly individual. On the other hand, they attack everything which separates the individual, breaks his link with others, splits up community life, forces the individual back on himself and ties him to his own identity in a constraining way … These struggles are not exactly for or against the ‘individual,’ but rather they are struggles against the ‘government of individualization’ … these present struggles revolve around the question: Who are we? They are a refusal of these abstractions, of economia and ideological state violence which ignore who we are individually, and also a refusal of a scientific or administrative inquisition which determines who one is … (Foucault, 1982, p. 211)

In his view, the struggle against (yet at the same time always for some different kind of) subjecthood is never against an institution of power, but rather against a technique of power. That form of power which “applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him” (Foucault, 1982, p. 212). It is the struggle against the form of power which makes individuals subjects. In this struggle against ourselves, to refuse who we are and to reconstitute ourselves, we can trace a long line of histories of struggle towards new subjectivities. It is work on this process, on the historical specificities in which subjects are formed and taken up, that I now turn.
2.2.5 Mad Subjects and Subjectivities in Context

In *The History of Sexuality* Foucault seeks to show how power deploys *through* the body – that the body is not effaced but rather *rendered* through the discourses that power operationalizes. He shows how, materially and discursively, sexuality has come to be a mode through which the individual has to pass “in order to have access to his own intelligibility … Hence the importance we ascribe to it, the reverential fear with which we surround it, the care we take to know it” (Foucault, 1978, pp. 155-56). His analysis works to show how we have come to understand ourselves as sexual beings – and thus as subjects to and of sexuality.

Foucault’s work on how the homosexual as a subject was made possible lends insight into the process through which identities of those experiencing madness have also come into being. Understandings of madness and mad people have varied throughout contexts, as have diagnostic interpretations. Since the 1960s, people who have encountered madness and/or the psychiatric systems have generated subject positions in order to differentiate themselves from dominant understandings of the mentally ill subject as the site where the problem is pinned. Self-identifying outside of the mentally ill role has led to a number of counter-identities that have proliferated in order to understand difference differently (often determined through experience). These self-labelling practices work in a way to counter current dominant understandings of mad people as biologically degenerate, and to articulate subjugated knowledge and subjectivities out of the medical case file and back into forms of cultural critique.

As scholars have documented (Church, 1995; Everett, 2000; Fabris, 2011; LeFrançois, Menzies, & Reaume, 2013; Morrison, 2005), individuals who have directly experienced the psy disciplines have come to identify their experiences through a variety of identity politics which underlie the becoming of new selves. In the 1960s and 70s, this included a reclamation of the language of
lunatic, identifying as ex-inmates (to signify forced carceral containment) and ex-patients (a refusal of the patient role), and social movements critiquing psychiatry solidified. In the 1970s, people began to identify as psychiatric survivors, an antagonistic subject position and subjectivity signifying that we had survived the negative consequences of the psychiatric system. Psychiatric survivor as a subject position connotes identifying as “surviving psychiatric treatment and moving beyond it” (Morrison, 2005, p. x) and, in essence, substituting the individualized mentally ill patient role and reconstituting oneself as an activist and advocate resisting the dominant definitions offered through psy systems. During the 1980s (to present day), the use of the language of patients shifted to some mental health organizations using the language of clients, meant to connote the reciprocal relationship of provider-client care (and some would say obscuring power relations and eclipsing lack of choice). During this time, the language of consumer also came into use to imply the exchange of goods and services between mad people and the psy and psychopharmacological industries. The most commonly used identity marker by mental health systems, those that identify as psychiatric consumers “demand information and choice in the treatment relationship” (Morrison, 2005, p. x).

Each of these identities that are taken up as subject positions and subjectivities are collectively used to challenge dominant understandings of madness as medically defined and as a way to ‘talk back to psychiatry’ and reconfigure ourselves as outside of the medical moment. As Morrision notes, “to question this authority by providing another standpoint is a charged and political act: to demand recognition of subordinate voices, the views of the people in the movement, of those who are silenced as objects of treatment, as people who are mad” (Morrison, 2005, xxi). But as Foucault points out, bringing these subjects into being can only be made possible through both defining and resistant technologies of subjectivity and self. These resisting selves and social movements are made possible through discontinuous segments of discourse and
context and moments that all together produce the possibility for such subject positions to be rendered comprehensible to the self and within the social. Simply put, in our current moment, while dominant discourse proclaims that mental illness is a hidden facet that needs to be brought ‘out of the shadows at last,’ our history of the present speaks continuously and amply about mental health and illness. Similar to how the Victorian era unpredictably substantiated sex acts as social identities, it has been through the dividing practices of mental heterogeneity that resistant identities have been able to proliferate and operationalize within our history of the present.

2.2.6 Dividing Subjects: Respectability/Degeneracy

Through processes of subject and subjectivity, some bodies become valorized, while other bodies become denigrated. Foucault situated theories of degeneration as arising in the Enlightenment through processes of pathologization and medicalization of both individuals and populations, and believed that “the discourse of degeneration should be understood in a longer history of the subject and in a wider ‘regime’ of discipline, surveillance and punishment” (Pick, 1989, p. 235). Mid-nineteenth century notions of degeneracy belonged to emerging discourses that linked race, pathology, biology, ancestry, and madness which worked in contrast against conceptions that the 19th century was ‘the classical age of progress.’ While popular belief that “humanity is perfectible and it moves incessantly from less good to better, from ignorance to science, from barbarism to civilization” (Pick, 1989, p. 12), progress was also continually positioned as under threat by an underlying degeneracy that was embodied by the racialized, the mad, the criminal, and so forth. In the 19th century, conceptions of degeneracy shifted: it was no longer a religious, philosophical or ethical problem, but rather became “an empirically demonstrable medical, biological or physical anthropological fact” (Pick, 1989, p. 20). In this context, degeneracy
became “a kind of self-producing pathological process – a causal agent in the blood, the body, and the race – which engendered a cycle of historical and social decline” (Pick, 1989, p. 22).

Degeneracy as a threat to civility burgeoned within the context of 19th century imperialism. It worked to solidify racial and biological inferiority onto the colonized in order to help justify colonization. As Edward Said notes in regards to the construction of the Oriental:

> Along with all othered peoples variously designated as backward, degenerate, uncivilized, and retarded, the Orientals were viewed in a framework constructed out of biological determinism and moral-political admonishment. The Oriental was linked thus to elements in Western society (delinquents, the insane, women, the poor) having in common an identity best described as lamentably alien. (Said as cited in Pick, 1989, p. 39)

While degeneracy was often used to define the racialized Other in European colonies, it was also used to define, mark and discipline the ‘internal enemies’ of the home country: those that threatened the civility, respectability, and progress of Western metropoles and white settler nations.

Fellows and Razack explain that degenerate subjects emerged to epitomize the antithesis of white middle-class respectability in Victorian-era England: “Respectability and its converse, degeneracy, were part of the nineteenth century ideological language expressing relations of domination and subordination. Respectability became an assertion of membership in the middle class and the basis on which one had the right to dominate others, those classified as degenerate” (Fellows & Razack, 1998, p. 346). Degeneracy came to signify a number of social and biological pathologies that the respectable citizenry had to protect themselves from and organize against. Degeneration became a biologically driven unknown that had to be both individually and population managed through biopower, as it threatened not only respectable citizens, but also provided an imprint for a number of internal dangers that threatened the safety of the respectable and progressive nation (Voronka, 2003, p. 22).
In this thesis, I draw on notions of degeneracy and respectability to connote both how individual subjects, entire sub-populations, experiences, and particular traits within the Canadian context are conceived as both degenerate and respectable. When I associate these concepts of degeneracy (madness, homelessness, street culture, poverty, etc.) to PWLE and peer works, I am not saying that we are in fact degenerate individuals or groups of degenerates. Rather, I am showing how our bodies and knowledges operate within conceptual frameworks that position us as holders of particular devalued, degenerated knowledge that needs to be made knowable through us. It needs to be conveyed through us so that respectable actors (most often referred to here as professionals), can come to know degeneracy through us: through what we convey. It is only through such knowledge that we as a population can be acted upon and contained and cured as the problem that we pose to respectability. Here, we see biopower in action.

In our current moment, neoliberal mental health and social service economies, in combination with seemingly contradictory social justice discourses such as the recovery movement, the crisis in representation, and social activism have converged and merged together to make new subject positions and subjectivities: people with lived experience and peer workers. Through both ‘progressive’ and ‘conservative’ technologies of subjectivity and self, dominant and resistant notions of subjects and subjectivities have emerged that have suddenly allowed for us to harness our predominantly devalued experiences of madness and contact with mental health systems in ways that offer us new powers, including as peer workers who can assert our authority through experience. As we continue to move towards using our experiential knowledge to work to change the psy disciplines, what can we learn from debates that have considered the possibilities, limits, and conditions of relying on experience to legitimize experiential authority?

2 Like any binaries, notions of respectability and degeneracy are fluid and situational.
2.3 Part Two: The Authority of Experience

Having reviewed how it is that we come to be, I now want to explore how we use our unique experiences to cultivate knowledge. Experience has always been an important element for making subjectivity, and drawing on notions of ‘everyday experience’ as knowledge has worked to refigure that power/knowledge rhizome. Drawing on lived experience has been important for racialized (Hill Collins, 1991) and feminist politics (Behar & Gordon, 1995), as well as standpoint theorists (Harding, 2004) to stake a claim in knowledge production. In this way, experiential knowledge has been used to unsettle knowledge as an objective science, and draw attention to how all knowledge production is situational and situated in particulars standpoints. Calling on this ‘I know because I am’ came under scrutiny in the early 1990’s, which sparked a theoretical debate on the value of experiential claims in poststructural and feminist thought (see Benhabib, Butler, Cornell & Fraser, 1995). Yet “others remind us again that what it comes to is not so much how different subjectivities are fabricated through power (as governmental theory tried to do), but how social reality is literally constructed and how subjectivity materializes in the social realm” (Blackman, Cromby, Hook, Papadopoulos, & Walkerdine, 2008, p.16).

Ordering particular experiences under the categories of ‘people with lived experience’ and ‘peer’ is a relatively new and emerging phenomenon, developing as a common practice within mental health fields in the past decade in Canada. Much of the research in this thesis stems from watching my own self and others respond to such a categorical call, and working to organize and order under it. As it stands, work in Disability Studies, Survivor Research, and Mad Studies has yet to engage with the limits of experiential claims. This has led me to engage in critical scholarship largely outside of mental health fields, in areas that were already in ongoing debate about the limits of experiential authority. Experience has always been an important element for making subjectivity, and drawing on notions of ‘everyday experience’ as knowledge has worked
to refigure both what is considered knowledge, and who are considered knowledge producers. It is this debate about the usefulness of experience to which I now turn.

Joan W. Scott’s seminal “The Evidence of Experience” (1991) was scholarship that altered the ways that critical theory, especially feminist and historical theory, engaged with the question of relying on experience to authorize power, and warrants here a close reading. The work begins with an exploration of the move within history-making to make visible histories that had hitherto been left unexplored; hidden accounts of sub-subjects, cultures, and populations that were now to be ‘discovered’ and known. This effort to bring forward subjugated histories for consideration has worked to multiply and complicate notions of a coherent, absolute history, and “the challenge to normative history has been described, in terms of conventional historical understandings of evidence, as an enlargement of the picture, a correction to oversights resulting from inaccurate or incomplete vision, and it has rested its claim to legitimacy on the authority of experience, the direct experience of others, as well as of the historian” (Scott 1991, p. 776). What this ‘subjugated retrieval’ work does is complicate history, multiply subject positions and subjectivities, and destabilize hegemonic accounts of what was, what is, and what can be.

Scott’s critique of this process (a process that much radical politics supports) is that by claiming to know, through experience, alternate truths, subjects become/remain the originary of knowledge. Key questions such as “the constructed nature of experience, about how subjects are constituted as different in the first place, about how one’s vision is structured – about language (discourse) and history – are left aside. The evidence of experience then becomes evidence for the fact of difference [italics added], rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world” (Scott, 1991, p.777). Such subjugated histories risk drawing on the very power of orthodox
history without challenging ‘history’ and its subjects epistemological frames. Nor does it get to
the root of the constructed nature of ‘difference.’ As Scott notes, such histories “take as self-
evident the identities of those whose experience is being documented and thus naturalize their
difference” (Scott, 1991, p.777).

Thus, Scott asks us to reflect on the risks of speaking from experience. Risks when
relying on expertise through experience include: what does working from difference solidify?
What are your narratives of othered experience producing? In whose interest do such acts risk
serving? Scott contends that experience-talk risks reproducing rather than undercutting given
ideological systems, and thus troubles experiential knowledge because this “project of making
experience visible precludes analysis of the workings of this system and of its historicity;
instead, it reproduces its terms” (Scott 1991, p. 779).

The task that Scott deems necessary when we work from our subject positions to
elucidate our experiences is to forefront how our subject/ivities and experiences are produced.
For that, Scott attests to the need

to attend to the historical processes that, through discourse, position subjects and produce
their experiences. It is not individuals who have experience, but subjects who are
constituted through experience. Experience in this definition then becomes not the origin
of our explanation, not the authoritative (because seen or felt) evidence that grounds what
is known, but rather that which we seek to explain, that about which knowledge is
produced. To think about experience in this way is to historicize it as well as to
historicize the identities it produces. This kind of historicizing represents a reply to the
many contemporary historians who have argued that an unproblematized ‘experience’ is
the foundation of their practice; it is a historicizing that implies critical scrutiny of all
explanatory categories usually taken for granted, including the category of experience.
(Scott 1991, pp. 779-780)

Scott’s ask is thus that we not only attend to subjugated histories, but also, crucially, to question
how such subjects and subjectivities are made possible, and what harnessing such experiences
produces. She argues that the emergence of concepts and identities are “historical events in need
of explanation” (Scott, 1991, p. 792), and thus related questions to ask with the development of ‘people with lived experience’ include what kinds of experiences, knowledge, and identities are taken as given and naturalized under such a category, and what is foreclosed through such accounts?

To be clear, understanding subject/ivities, identities, and experiences as discursive processes does not deprive subjects of agency. Rather, it is to insist on the productive value of discourse in the making and enabling of subjects. While it does mean letting go of notions of the sovereign self, subjects, instead of being naturalized, must always be considered contextual, contested, and contingent. Inquiries should work to reveal not only that which has been subjugated, but also question how “class, race, gender, relations of production, biology, identity, subjectivity, agency, experience, even culture – achieve their foundational status? What have been the effects of their articulations” (Scott 1991, p. 796)? By attending to how ‘experience’ is worked with, on, and through means “focusing on processes of identity production, insisting on the discursive nature of ‘experience’ and on the politics of its construction” (Scott, 1991, p. 797).

Following Scott’s call, critical scholarship has expanded inquiries into the limits of relying on experience to authorize knowledge, as well as what this means in research praxis (Jackson & Mazzai, 2009; Razack, Smith, & Thobani, 2010). For example, Grant’s recent work asks that mental health qualitative research move beyond the “implicit and taken-for-granted meta-assumption: that it is possible to trust in ‘lived experience’” (Grant 2014, p. 554). Rather, Grant notes that narratives that are usually represented as linear, tidy, and static foreclose the discordant, shifting, and contradictory nature of experience and becoming. While he calls into question conventional qualitative assumptions on how ‘lived experience’ is taken up in order “to trouble the literal representation of voice, assumed identity and communities of identity and
universally shared reality positions” (Grant 2014, p. 547), his analysis stops short of holding those of us who deploy ‘lived experience’ accountable for how we too rely on such assumptions to attain and authorize our power.

In the 2008 inaugural issue of the journal Subjectivities, the editorial team wrote that while post-structural debates launched a mistrust of experience and standpoint epistemologies, we still need to map how experience, subjects, and subjectivities materialize in the social realm, and in particular attend to what such bodies produce. That means inquiries which focus “on bodies, where bodies are not singular, bounded, closed and fixed, but rather open to being affected and affecting others. Within this formulation attention is shifted to what bodies can do, and what relational connections change and alter bodies as they move and sense in the world” (Blackman et al., 2008, p. 16). This is precisely what my research does: it maps not only the emergence of the new subject positions and subjectivities of people with lived experience and peer workers, but also what the conditions, possibilities and limits of working through such manifestations. Further, our experiential knowledge proves valuable when used to manage and govern ourselves and those like us, but when we attempt to use our ‘experience’ to penetrate, shift and inform conceptual, scientific, and large-scale structural practices, we are met with limited success.

2.3.1 Feminists Debate Experience

Scott’s article, even though drawing on a long line of ‘post’ critiques, launched a large debate amongst feminist scholars because it was understood as an attack on “speaking from experience” – a foundational move that feminist scholars rely on to ground their stake in power/knowledge.

In Feminist Contentions: A Philosophical Exchange co-authors Selya Behabib, Judith Butler, Drucilla Cornell, and Nancy Fraser engage in the debate over, among other things, what it means to radical movements in general and feminist ones in particular when subjectivity, identity, and
experience as essentialist givens are challenged. Feminist critiques against ‘post’ conceptions of subjects (and everything else) being discursively produced are many: Fraser contends that post approaches to subjectivity are “antihumanist” and that Butler’s use of language in particular is remote, inaccessible and thus “far removed from our everyday ways of talking and thinking about ourselves to require some justification” (Fraser, 1995, pp. 67-68).

Other critiques to post approaches from a feminist lens insist that post approaches to the ‘death of man, history and metaphysics’ under a ‘strong formulation’ “eliminates the idea of subjectivity altogether. By doing so, it eliminates those ideals of autonomy, reflexivity, and accountability which are necessary to the idea of change” (Nicholson as cited in Benhabib et al., 1995, p. 3). Fraser begs for consideration histories that allow for “a plurality of narratives, with some as possibly big and, all, of whatever size, as politically engaged” (Nicholson as cited in Benhabib et al., 1995, p. 6). The issue of the impossibility of agency without subjects existing outside of power has been discussed in previous sections, but within this textual debate Butler responds by reiterating that “we may be tempted to think that to assume the subject in advance is necessary in order to safeguard the agency of the subject. But to claim that the subject is constituted is not to claim that it is determined; on the contrary, the constituted character of the subject is the very precondition of its agency” (Butler, 1995, p. 45). The subject as a site of (re)signification does not do away with subject agency, but rather, allows for “a call to rework that notion outside the terms of an epistemological given” (Butler, 1995, p. 48).

The need to be mindful that when one speaks, makes a move, or calls to action, that others are automatically excluded through these movements is also up for debate. Butler insists that “subjects are constituted through exclusion, that is, through the creation of a domain of deauthorized subjects, presubjects, figures of abjection, populations erased from view” (Butler,
Drawing on Foucault’s premise that the constitution of the subjectivity of some necessitates the exclusion of others, Fraser questions “is it really the case that no one can become the subject of speech without others being silenced? … is subject-authorization inherently a zero-sum game” (1995, p. 7)? Premises such as these seem to unsettle feminists, as they work to decentre the authority that is evoked when speaking from identity, and implicate (even) feminists in systems of oppression that we would all prefer to understand ourselves as working “outside of.” This race to innocence (see Fellows & Razack, 1998) cannot be accomplished within post approaches to subjectivity, which calls into contention our understanding of ourselves as good feminists and as operating outside of power.

Butler pushes us to ask “through what exclusions has the feminist subject been constructed, and how do those excluded domains return to haunt the ‘integrity’ and ‘unity’ of the feminist ‘we’” (Butler, 1995, p. 48). Marking how drawing on a particular essentialized subjectivity relies on bringing other bodies into jeopardy, Butler asks feminists ‘what is at risk’ when staking claims to universal woman, and why are we so invested in protecting the very models of domination that have sustained oppressions? She asks us:

Do women want to become subjects on the model which requires and produces an anterior region of abjection, or must feminism become a process which is self-critical about the processes that produce and destabilize identity categories? To take the construction of the subject as a political problematic is not the same as doing away with the subject … on the contrary, deconstruction implies only that we suspend all commitments to that to which the term, “the subject,” refers, and that we consider the linguistic functions it serves in the consolidation and concealment of authority. (Butler, 1995, pp. 48-49)

Butler asserts that identity categories are always normative, and as such, always exclusionary to others who fall outside of whatever constitutes a said norm. She admits that drawing on identity politics and strategic essentialism is often necessary for political and legislative effects, and is not advocating for the end of claim-making in the name of ‘women.’ But what ‘woman’ has
come to signify is now fixed and naturalized, and instead of being threatened by ‘woman as subject’ being called into question, it should been understood rather as opportunity: “to deconstruct the subject of feminism is … to release the term into a future of multiple significations, to emancipate it from maternal and racist ontologies to which it has been restricted, and to give it play as a site where unanticipated meaning might come to bear” (Butler, 1995, p. 50).

This ongoing discussion between ‘feminists’ and ‘postmodernists’ is one that Marianna Valverde addresses in Experience and Truthtelling in a Post-humanist World, where she attempts to “cut through this rather stale debate” (Valverde, 2004, p. 67). She characterizes this divide as “some feminists, in the academy and outside, sing[ing] the praises of any and all autobiographical accounts – whereas the skeptics, often gathered under the misleading banner of ‘postmodernism,’ tend to see the quest for authenticity as deluded, and the construction of a unified humanist feminist subject as an ideological and political trap” (Valverde, 2004, p. 67). Valverde works to collapse this dividing practice by orienting us towards “a more modest pursuit, namely, the documentation of the rich variety of gendered dialogic practices” (Valverde, 2004, p. 67).

Taking up Butler’s work on subject-making, Valverde draws on Deleuze and Foucault’s later work on ethics to argue that “personal truth telling need not be “confessional,” or even at all psychological” and that “Foucault came to the conclusion that not all personal truth telling assumes or produces the mythical humanist subject and its naïve theory of meaning as generated by the individual mind” (Valverde, 2004, p. 71). In essence, Valverde – not at all contrary to Butler, as we have seen – feels that we should be able to “acknowledge the need to continue to engage in truth-telling exercises even if we no longer believe in absolute truth” (Valverde, 2004, p. 74).
She goes on to make an interesting theoretical move, noting that Foucault himself often relied on the study of “low-status texts” to elucidate social relations in new ways. Thus, while many autobiographical and “speaking from experience” texts are critiqued under ‘post’ approaches, Valverde argues that Foucault would invite us to find value in such ‘minor’ self explorations. She remarks that “rather than claiming that a particular text or set of texts (autobiographical tales of intoxication, addiction, and recovery, in this case) should be regarded as Literary or Philosophical, [Foucault] exposes the ways in which the work done on the front lines by those inventing, evaluating and trying out ‘minor practices’ have left a rich archive documenting, and often critically analyzing, the main techniques of governance characterizing advanced capitalist societies” (Valverde, 2002, p. 4). In defense of attending to accounting for oneself, she points out that many of us aren’t seeking to tell the Truth, but rather are seeking to tell minor truths that enable us to conduct everyday life. However, “there is still the activity, the process of truth telling. And while the activity of monitoring oneself and speaking about oneself is of course constitutive of ‘the self,’ this is by no means a unitary or univocal process: there are as many different kinds of selves as there are ways of embarking upon and continually practicing truth telling … we might find that although there is no longer any Truth, nevertheless truth telling remains an integral part of ethical reflection” (Valverde, 2004, p. 88).

In exploring this ‘post’ versus feminist debate on the usefulness and status of experience, some things are made clear. Feminists are still committed to use experience to multiply and disperse a plurality of narratives to complicate History into a proliferation of histories, in effect multiplying empiricisms and decentering modern-man metanarratives. Indeed, my everyday work as a consumer research consultant for the At Home/Chez Soi project positioned me continuously as an interrupting body and subject that offered a visceral reminder that The Story of the homeless mentally ill cannot be one singular narrative of abject bodies in need of constant intervention.
This writing, however, offers the opportunity for more than just multiplying experiences. This undertaking draws on ‘post’ approaches that are instead committed to using experience to elucidate what identities, knowledge, and cultural production such experience actually produces and solidifies. It is important to note that both approaches are vested in the power/knowledge that their disciplines promote (i.e. ‘post’ approaches operate within discursive constrains inasmuch any other approaches do). Regardless, both approaches concede that speaking from experience is an activity that will remain necessary in order to advance and change how we and the world around us are constituted. The question remains, what does becoming a ‘person with lived experience’ do to entrench, remake, and disrupt notions of the experience, knowledge, and identity of mad people?

2.3.2 The Trouble with People with Lived Experience

In this section I draw on some of the threads that these theoretical debates evoke and consider them within the specific context of the emergence of ‘people with lived experience’ as an organizing category within mental health research and service provision. In particular, I question what it means and what it does for our involvement, to mark ‘people with lived experience’ as a new formation. I aim to destabilize its emergence as naturalized, and to begin to trouble what it does to be hailed as people with lived experience. Further, what happens when we respond to such hailing in the context of working in mental health systems: how do our bodies move and work through social realms when we embody lived experience? How can those of us who position ourselves collectively as ‘people with lived experience’ yet are fractured across divergent ontological and epistemological frames, use critical and post-structural lines of inquiry to think through what we risk solidifying and disrupting when we work to speak and act from a
generalized notion of expertise through lived experience? And finally, as this study explores, how is the knowledge that ‘people with lived experience’ hold constructed?

Many of us who are active in critical social support, action, activism, advocacy, and academia have worked hard to attend to the different ways in which we understand distress and the psy disciplines, and try to attend to the interlocking differences amongst us as they pertain to identity, socio-political contexts, and individual variances in how we experience distress and the interventions that result. All of us have different ways of interpreting our experiences of distress, and of interpreting interventions. Indeed, how we come to understand our experiences is often indicated by how we self-identify. The sometimes obvious, other times intricate, ways in which we chose to self-refer shows how experience in and of itself does not determine how we make sense of and use it. Through technologies of subjectivity and self, we relate to our experiences in a variety of ways. We draw on signifiers that signify a diversity of meanings to explain how we have come to make sense of our experiences: from the mentally ill, person living with a mental illness, peer, service user, person with lived experience, consumer, psychiatric survivor, ex-patient, mad-identified, and more, we take up experience and identity in different ways in different contexts, drawing on dominant scientific, psycho-social and resistant identities (and often a mix) to make meaning.

Yet, when we act under the suddenly common rubric of ‘person with lived experience’ as a universalizing identity, we are inevitably enacting strategic essentialism. That is, “acting ‘as if’ identities are stable for specific political reasons. For example, one might temporarily accept the category of ‘woman’ as a stable unity for the purpose of mobilizing women for political action” (Barker as cited in Ray 2009, p. 110). Promoting notions of a shared universal identity amongst those marked different in order to achieve socio-political, economic, human rights, or other
equity gains has been both endorsed and troubled in much critical theory (Alcoff, Mohanty, Hames-Garcia & Moya, 2006). Currently, we are drawing on notions of universally shared ‘lived experience’ in order to gain access and advantage within systems of knowledge production. We do so because we must, because it is often the only way that we can get in. Yet Spivak has argued that while it may be advantageous at times to reduce one’s self to an essence, we must always do so while “remembering the dangers in this” (Spivak, 1990b, p. 45).

One such danger in universalizing heterogeneous bodies into essentilaized identities in order to move action forward is that “essentialism appeals to the idea that there are fixed identities, visible to us as social or natural facts” (Scott, 1991, p. 791). It reifies notions of normalcy and difference as embodied truths. Fellows and Razack note how normalcy requires no marking, while “identity boxes contain those excluded from the dominant group. Conversely, to be unmarked or unnamed is to belong to the dominant group. The marking of subordinate groups and the unmarking of dominant groups leaves the actual processes of domination obscured, thus intact. Subordinate groups simply are the way they are; their condition is naturalized” (1998, p. 341).

Mental health organizations and individuals use a variety of discursive frames to describe difference: in Canada in recent years, the turn away from ‘consumer’ and ‘consumer/survivor’ towards favouring ‘people with lived experience’ marks new formulations that require unsettling. Drawing on language that is ‘all-inclusive’ and that works to unify diversity has risks. By subsuming all of the ways in which we have made sense of our experience (mad, psych survivor, mentally ill, and so on) under the umbrella of ‘lived experience,’ we risk conflating distinct ideological and conceptual explanatory models under the apolitical, liberal, and user-friendly language of ‘lived experience,’ effacing the critical edges and differences that many of us have
worked so hard to elucidate. How we come to understand ourselves and others in the social realm influences what directed actions, issues, and change we challenge, support, and condone. These factions amongst us are often cited as working against us: as preventing us from being able to work as a collective mass. We often must ignore them in our efforts to make change.

Epistemological frames that work outside of mental illness are also often ignored by systems of power, cited as irrelevant, petty semantics, or worse (for instance, as a sign of our madness) when we move to work within, alongside and/or against the psy disciplines. But it is important for us to attend to the fact that our experiences of madness/distress do not translate into meaning that we all share the same collective conceptual, positional, and material vested interests that we are working towards. As critical anti-racist, transcultural feminist and post-colonial scholarship has shown us, it is the very conceptual and material divides between us that require attention (Patel, 2014; Tam, 2013). When we move to obscure the wide differences amongst us through universalized notions of ‘lived experience,’ we risk erasing fundamental differences amongst us that matter.

Dangers when we strategically essentialize lived experience include whitewashing how madness lands and is graphed on bodies differently. Depending on other ‘essences’ that are always operating in collusion with madness, including race, class, sexual and gender-identity, citizenship, and so on, universalizing lived experience risks effacing how systems of power require one another, and the material consequences of such biopower. Further, the differences in how madness is experienced become subsumed. Universalizing ourselves as ‘experts by experience’ belies the ways in which the variances that our bodies carry and how we experience madness and mental health fields of power diverge. It also requires us to ask – whose experience gets qualified as expertise? Kalathil notes that “user involvement in the last few years has shown
that people from marginalized and minority groups have not had a substantial role in involvement initiatives” (Kalathil, 2013, p. 122). Other work has also called into question whose bodies are understood as able to work as experts by experience (Lindow, 1999). What are the conditions of recognizing the self as a ‘person with lived experience’? Perhaps more importantly, what are the conditions of being recognized as a viable ‘lived experience’ body able to work within mental health assemblages? In my view, these bodies are by and large ones recognized as able to perform white civility, comprehensibility, and self-manage unruliness (Coleman, 2008). Thus, it can actually be sites of privilege that allow for self/recognition of the body as qualifying as ‘lived experience’ proper.

We need to mark how ‘people with lived experience’ risks reproducing and replicating systems of domination which privileges subjects and subjectivities that fit closely within the white heteropatriarchal matrix of ruling, which in turn risks reproducing representation that aligns with white, middle-class, sanist, capitalist, and biomedical investments (see Gorman, 2013). Some questions that this thesis asks about ‘people with lived experience’ as it emerges as a universal and universalizing category include: how is ‘lived experience’ becoming defined and operationalized? What tacit rules govern the speech, experience, and behaviours of those seeking recognition as ‘people with lived experience’? Who and what is excluded as ‘lived experience’ solidifies in meaning and making? How is our knowledge as ‘experiential knowledge’ used, regulated, and discounted? And how can we attend to the making of people with lived experience as a development “which is self-critical about the processes that produce and destabilize identity categories” (Butler, 1995, p. 48)?
2.4 Conclusion: Experience as Knowledge

This study, by exploring the emergence, performance, and performativity of ‘people with lived experience’ as peer workers within the case study of the At Home/Chez Soi project charts how people with experiences of distress/mental health systems come to recognize themselves as such. Through this process of interpellation, I show the often conflicting ways in which we forge ourselves as comprehensible to ourselves and others as ‘peer workers.’ I demonstrate that identity-making is an active process which requires strategies of making the self, which align with post-structuralist understandings of the subject and subjectivity as discursively rendered. Importantly, I chart not only how we perform such identity, but also what such performance produces.

One novel contribution that this study offers is an exploration of how particular individuals and populations become identified as possessing knowledge based on experience, and how such knowledge comes to be seen as a form of expertise that grants us authority. While as ‘people with lived experience,’ our once subjugated knowledge is now proclaimed to be valorized in our roles as peer workers, how is the knowledge that we bring to mental health intervention projects conceived and operationalized? To answer this question, in Chapter 6 I draw on Mohanram’s (1999) *Black Body: Women, Colonialism, and Space* to show how particular forms of knowledge become attributed to particular bodies, which impact conceptions of what kinds of bodies are suitable for particular forms of labour. To illustrate this process, I here draw on the analogy of social science scholarship, how knowledge production is organized, and the difference between ‘studying up’ and ‘studying down.’

‘Studying down’ broadly means undertaking studies which focus attention on the problems within marginalized communities: the focus remains on the problems that need to be fixed within
communities of difference to help solve such difference because of the problems it poses to normalcy. Conversely, ‘studying up’ means focusing instead on systems and cultures of power, and how such regimes are implicated in the making of marginality. I argue that the ‘useful’ knowledge that peer workers bring to mental health interventions is conceived, organized, and operationalized in ways that fit with the anthropological concept of ‘studying down’: scholarship which focuses on marginalized populations and the problems they are seen to represent and pose (Nadar, 1972). To draw a parallel, peer knowledge is harnessed as useful when it is ‘working down’: that is when our knowledge is put to use to target, inform, and help in the governance of the ‘mentally ill.’ Our knowledge is largely conceived as ‘personal’ embodied knowledge that stems from our own experiences of marginality. As ‘useful knowledge,’ our experiences become siphoned into a knowledge base which is used to help inform the helping professions. That is, as peer informants, our knowledge is organized in ways which offer professionals better insight into our condition, and our work is understood as most effective when we are brought into work roles in which we manage and govern subjected bodies.

Conversely, the anthropological concept of ‘studying up’ helps to illustrate how peer knowledge is not conceived nor put to use. Nader’s seminal work “Up the Anthropologist- Perspectives Gained from Studying up” is crucial here. She argues for a shift in anthropology’s focus away from ‘exotic’ marginalized social problems and focus inquiries instead towards that which remains untroubled. Instead of ‘studying down,’ Nader asks, “What if, in reinventing anthropology, anthropologists were to study the colonizers rather than the colonized, the culture of power rather than the culture of the powerless, the culture of affluence rather than the culture of poverty” (1972, p. 289). This shift would lead to different inquiries, such as “instead of asking why some people are poor, we would ask why other people are so affluent?” (Nader, 1972, p.
Thus, ‘studying up’ means refocussing problematics which elucidate those systems of power which enable marginality to re/produce.

To extend this analysis to how peer knowledge is organized, I show that peer work is less effective when we make efforts at ‘working up.’ That is, when we attempt to use our experiential knowledge in conceptual and analytic ways which target not the ‘mentally ill,’ but rather the regimes of truth and power that govern us, our work often meets a dead end. Indeed, I show that peer work is organized in ways which fundamentally rest on the premise that the insights that we bring to the table are about ‘similar others,’ and that work that challenges discursive fields of power is simply not accepted as part of our work. As my own labour and that of peer workers that I interviewed show, we learn the boundaries that occupying such an identity precludes. That is, we are successful peer workers when we keep our locus of focus to ‘working down’ on marginalized bodies. When we make attempts at ‘working up’ by focusing on systems of power which constitute us as subordinate bodies, our work is blocked, rendered useless, or understood as unruly.

By drawing on the theoretical frameworks detailed in this chapter, the following chapter maps both the emergence of the Mental Health Commission of Canada and the At Home/Chez Soi project as novel forms of neoliberal governance that have emerged in Canada in the last decade.
Chapter 2
Mental Illness and Inclusion as a Technology of Rule

3.1 Introduction

This chapter explores the various technologies of government that form broadly around mental illness, as well as specifically around ‘the homeless mentally ill.’ Divided in two parts, the first explores the creation of the Mental Health Commission of Canada (MHCC) in 2007. I show that the Commission can be viewed as a new national enterprise which approaches mental health and illness in specific ways. Through its formation, we see how tactics of national crisis and science, a common threat and assemblages are forged to govern mental illness. I show how the inclusion of people with lived experience as participants in this project position us as key players in this process. Thus, I argue that inclusion is a key technology of governance. I show how such inclusionary technologies take place within various neoliberal formations: within neoliberal policy and corporate structures, discourses, and as governmentality.

Part Two of this chapter maps the making of the At Home/Chez Soi project, a national research demonstration project administered through the MHCC, which studied how to best house the homeless mentally ill. I lay the groundwork for understanding the At Home/Chez Soi project as a new intervention which draws on open forms of governance through the Housing First program model, which significantly restructures how housing and mental health service systems are offered. I show how technologies of choice, responsibility, citizenship rights, and new forms of neoliberal biopower together map a new landscape for social and health interventions. The At Home/Chez Soi project as a research demonstration project is crucial for understanding how peer participation emerged within the project. Not only a housing and mental health service, the
The Mental Health Commission of Canada was officially launched on Friday August 31st 2007, and Prime Minister Stephen Harper made the announcement during the 2007 International Initiative on Mental Health Leadership Exchange and Conference in Ottawa (PM officially launches, 2007, ¶ 3). In his speech, Harper references the pervasiveness of mental illness, noting that while

> The causes may be unclear, the consequences are obvious. We see mental illness everywhere – among the homeless on our streets. We see it in our workplaces, among our co-workers felled by stress or worse, and we see it in our families, where we become intimately acquainted with the pain and suffering it causes. It is estimated that one in five Canadians will develop some kind of mental illness in his or her lifetime. Nearly one million are plagued with a severe or persistent disorder, and it’s now the fastest-growing category of disability insurance claims in Canada. (Harper, 2007, pp.1-2)

There is a problem here: it is a problem which poses threats to individuals, families, society, economy, and the nation. But we will come to know the problem better, and offer better
solutions, through the MHCC. Harper wraps up his announcement with this speech act: “Mental illness has a significant impact on all our lives. It visits us in our homes, our workplaces and on the streets of our communities. It costs our economy billions and our society untold grief” (Harper, 2007, p. 3).

Coverage of the Commission launch was positive across a variety of media, portrayed as the development of a useful organization needed to coordinate and strategize against this recurrent national crisis of mental illness. Former Liberal Senator Michael Kirby was named first Chair of the Board, and press coverage quotes him as encouraged by the response to the development of the MHCC: “there is already widespread enthusiasm for the creation of the commission” and “I cannot count the number of offers of help and proposals for collaboration that have already flooded in” (PM officially launches, 2007, ¶ 10), and that “above all, the commission must ensure that mental health issues are never again allowed to retreat back into the shadows” (PM names board, 2007, ¶ 13). The Globe and Mail quotes Kirby as saying that “in many large urban centres in Canada, there is not a single pediatric psychiatric unit. If there were no medical beds for children with childhood leukemia, heart problems or other medical problems, we as a society would be outraged” (Curry, 2007, p. 1).

There is significant emphasis on the mental health community’s interest in being on board, and wanting to be on the Board of Directors. The PM noted that “The board members were chosen from close to 500 applicants after broad public consultation. They represent the best minds in Canada’s mental health field today. In addition to their extensive professional qualifications, many have first-hand experience of mental illness within their families. As a result, they have profound empathy for the mentally ill and unique insight into how we can respond to this national challenge” (Harper, 2007, p. 3). The diverse make-up of the Board is also noted in
media coverage: not only made up of six federal, provincial, and territorial former and current senior government bureaucrats, but also those from broad community interests, including “three people living with mental illness, two aboriginals and representatives of care-giving agencies, professional support groups and community groups” (PM names board, 2007, ¶ 4-5). From the outset, part of the new ways in which the problem of mental illness will be solved is through diversity, inclusion and representation: a diversity of populations and expertise is represented, many of whom have been excluded in the past. A wide range of individuals are being brought to the project to share their knowledge of and from their particular fields and populations, and forge attempts at total knowledge. As I show in this thesis, inclusion becomes a major technology of rule.

3.2.1 Framing the Current Mental Health Moment as National Crisis

Federal investment in the first ever national mental health commission is a new addition to strategies of governing mental illness. The founding of the Mental Health Commission of Canada adds to the long history of recognizing and intervening on the problem of madness. From the building of its first asylums in the 19th century, to mental hygiene in the early 20th century, from deinstitutionalization to the now common refrain of community care, mental illness has been invested in, contested, and reworked (see Dowbiggin, 2011; Hudson, 2000; Shorter, 1996). But building the Mental Health Commission of Canada further solidifies the problem as a national one, even though health and social care is usually left coordinated by individual provinces/territories and municipalities. Building a national commission to address mental illness makes mental illness a national crisis. Investing in mental health and illness as a national project also builds the Federal Conservative Government as surprisingly invested in the mental wellbeing of its nation, and works to “satisfy those who contend that governments were not
doing enough to ease the burdens of families and patients who live with crushing emotional pain” (Dowbiggin, 2011, p. 7).

The process of creating the Commission was a public affair, filled with years of cross-Canadian consultations and contributors. Enjoining a variety of stakeholders, including governments, medical professionals, researchers, industry leaders, family members, Indigenous peoples, and notably, people with lived experience, who as individuals may disagree as to the state of madness and its problems in Canada, but do all together agree that there are problems that need to be addressed. As Dowbiggin notes, “though sometimes at cross-purposes, these vested interest groups have been united on the basis of an evolving consensus emphasizing the virtues of bureaucracy, welfare, education, science, professional expertise, and public administration” (Dowbiggin, 2011, p. 2). Notably, in both the report and the building of the commission’s Board of Directors, there is emphasis on the inclusion of ‘people with lived experience’ of mental illness as central to the vision of this new adventure.

Madness has always mattered in Canada, and is always in processes of reform. But the urge to organize nationally against what some view as an epidemic is one that has garnered new ground since the development of the Mental Health Commission of Canada. Phillips notes that madness in Canada “is not a new problem. However, this more recent flurry of documents, in addition to the issue being taken up at the national level whereas mental health has always been a provincial mandate, all indicate that it is being problematized in new ways” (Phillips, 2013, p. 1) I approach the formation of the Mental Health Commission of Canada as a substantive addition to the regime of practices that produce knowledge about mental health and illness in Canada through a variety of methods: research, campaigns, policy work, training, expertise, conferences,
frameworks, workshops, media, service provision, and revision. This works towards governing at a distance, through the conduct of conduct (Foucault, 1994).

In Part One of this chapter, I start by looking at how the MHCC works as a regime of practices that, through the will to know and the will to truth, re-produce regimes of truth. I then explore how biopower and normalization are bound to such systems of governance. I show how the MHCC works within and through technologies of governance that build mental illness as a national crisis, a crisis that can be known and managed by science, as well as by self-governance. I also discuss how much of the work of the Commission relies on forms of inclusionary practices that simultaneously reflect a diversity of interests and operate as a key technology of governing. I introduce people with lived experience and peer workers as key players who are both targets and instruments in this strategy. I then show how such governance works well within neoliberal configurations of social policy, ideology/discourse, and governance.

The MHCC is an interesting formation, conceived of as an autonomous body made up of heterogeneous experts in varying fields, all with vested interests in making things better for the welfare of all Canadians. Madness, mental illness, and mental health are social projects that have long been conceived of as ‘problems’ that have called for a multitude of reformatory interventions. The MHCC offers a modern approach: the organization is situated on the cusp of the state and society, neither yet both, soothing in its sovereignty. It is situated at the nexus of Foucault’s triangulation of governance, calling into power the art of “sovereignty-discipline-government, which has at its primary target the population and as its essential mechanism the apparatuses of security” (Foucault, 1991a, p. 102). The problem is mental illness, and this is a problem that is located in the mentally ill. As Ashforth notes, to “view some peoples’ lives as a ‘problem’ is to name those people as a subject to power, the power presumed capable of
‘solving’ the problem that they constitute” (Ashforth, 1990, p. 17). Ashforth’s work on commissions of inquiry reveals how “dimensions of commission work . . . can reveal some of the discursive formations underlying State power: ways of speaking about social life which make possible the work of organizing political subjection” (Ashforth, 1990, p. 17). The formation of the MHCC shows us, in this history of our present, the proper mechanisms that must be in place in order for it to identify problems, find facts, and offer solutions that can be accepted as authoritative and objective.

The MHCC offers novel regimes of practices that work to harness and create powerfully interactive mechanisms for producing expert discourses that inform the nation that it is doing the work that it should: drawing on pure science, best practices, grey sciences, psy disciplines, evidence-based research, and benevolence – the things that make Canada a progressive, advanced (neo)liberal nation. Here, drawing on Foucault, I explore the MHCC as a nexus of regimes of practices, “with the aim of grasping the conditions which make these acceptable at a given moment . . . as places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect. To analyze ‘regimes of practices’ means to analyze programmes of conduct which have both prescriptive effects regarding what is to be done . . . and codifying effects, regarding what is to be known” (Foucault, 1991b, p. 75).

The MHCC, through its regimes of practices, produces both directives on what should be known, and what should be done through such knowledge. Following Foucault, my focus here is not in asking “what, in a given period, is regarded as sanity or insanity” but rather “how these divisions are operated” (Foucault, 1991b, p.74) through Commission work. The MHCC’s work takes some truths as given, while others as in need of identification. More truths are generated on what needs
to be done once truths are produced and ordered. At the same time other discourses are rendered false, denied, subjugated, and discarded. Through these processes, regimes of truth are further generated and dispersed (knowledge exchange), allowing truth statements to circulate, solidify, and reproduce. These regimes of truth come to “underpin what is taken to be ‘common-sense’ knowledge … Each society has its own ‘regime of truth,’ that is, the type of statements which can be made by authorized people” (Mills, 2003, p. 74).

3.2.2 Biopower & Normalization

The MHCC works to orient populations towards thinking, acting, and reacting to notions of mental health and illness in an assortment of ways. As Foucault notes

> Population comes to appear above all else as the ultimate end of government. In contrast to sovereignty, government has at its purpose not the act of government itself, but the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.; and the means that the government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, without the full awareness of the people, the stimulation of birth rates, the directing of the flow of population into certain regions or activities, etc. (Foucault, 1991a, p. 100)

The MHCC must come to know the ‘mad’ population and those that serve it, ask this population to know and identify itself, as well as come to understand the variety of techniques that are in place to intervene on these populations. As White notes, “In every aspect of the Commission’s work madness is reified as both an illness – a “disease” – and a threat to the nation’s socioeconomic health. In addressing the problems associated with mental illness in Canada … the MHCC is officially charged with the task of privileging and laying claim to certain kinds of knowledge (regarding signs, causes, effects and solutions) as the best knowledges, and certain kinds of practices (directed toward intervention, prevention, treatment and management) as the best practices” (White, 2009, p. 228). Through truth-making, problem-solving, scientific
expertise, and dissemination of official knowledges, populations will be called to act upon themselves through the will to know, the will to truth.

An example of this is how the Commission positions itself as advancing both the biomedical (science) approach and the recovery model (social science) approach to mental health and illness. Thus both biomedical and self-governing strategies now play key roles in managing mental illness: “The bio-medical approach would focus on ‘teaching people to identify signs and symptoms of illness and understanding treatment approaches,” while the recovery approach would foster “a new sense of optimism, address self-stigma and encourages personal responsibility in looking at ‘mental illness’” (White, 2009, p. 236). The recovery model, which I discuss in great detail in Chapter 3, is key to how an assemblage of knowledge, both scientific and non-scientific, are now united and relied on in order to govern mental illness. Significantly, the recovery model evokes the will towards self-governance and promotes individual responsibilization in ways that shift accountability from the state onto the self.

Foucault’s concept of bio-power illustrates how these projects can work to govern (both sane and insane) populations, and more generally to solidify the right to normality. Implicit in the quest to cure mental illness is that madness negates the right to a true life. That madness impedes the liberal humanist individual’s quest towards “the ‘right’ to life, to one’s body, to health, to happiness, to the satisfaction of needs . . . the ‘right’ to rediscover what one is and all that one can be” (Foucault, 1978, p. 145). Foucault and others (Mills, 2003; Pilgrim & Rogers, 2005; Rose, 2007) have shown that surveys, polls, campaigns and committees can have the effect, under the pretence of improving the welfare and common good of a society, to tighten “the disciplinary regime, so that the population [is] more strictly controlled” (Mills, 2003, p. 84). Through collecting and dispersing power/knowledge, populations come to know themselves
through what they are, and what they are not: constantly re-constituting themselves against the
grain of the Other. That is, constantly doing the work of building the right to life. In Foucault’s
words, it “is not that life has been totally integrated into techniques that govern and administer it;
it constantly escapes them” (Foucault, 1978, p. 143). The art of governance must work to ensure
that populations have access to the rights to live, to the “indispensable, the useful, and the
superfluous: those are the three types of things that we need, or that we can use in our lives. That
people survive, that people live, that people do even better than just survive or live” (Foucault,
1994, p. 413).

But the fact that projects of normalization are always failing “does not lead to the abandonment
of the dream of secure administration of troublesome sectors of the population . . . rather, it leads
to demands for more information to be noted in better files, for more coordination between
different professionals, for tighter standards, codes of conduct and so forth” (Rose, 1996b: 18).
For an always improvable conduct of conduct. The constant potential to slip, from the realm of
the normal to the abnormal, calls and allows for the potency of projects such as the MHCC to
intervene and re-act under the name of securing the common good. The work of these projects
should thus also be understood also as a way of reaffirming bourgeois respectable citizenry:
“These vulnerable groups are simply a medium through which the larger population is
continually re-normalized to be in accord with the social order . . . it is the disciplining and
normalizing of productive citizens” (Scheurich, 1994, p. 312). Not only is the citizenry
reaffirmed, but the interventions are rarely identified as part of the problematic. As Scheurich
notes, “that fundamental social problems, such as poverty or homelessness or racial prejudice,
are never really ‘solved’ is generally not taken as a negative judgement on professionals or on
professionalization. The public performance of the treatment of the problem group by the
professionals, even if it fails, as it typically does, satisfies society that it is doing its best” (Scheurich, 1994, p. 10). Thus, the mad are re-made through the implementation of the MHCC, and so too are diverse fields of professionals who are solidified as experts in the field as they move through the process of re-working through regimes of practices towards producing more regimes of truth.

3.2.3 Universalism and People with Lived Experience

Throughout the development of the Commission, the notion is put forward that mental illness affects us all: that we know someone with mental illness. Thus we are all implicated in investing to work on this issue, as well as authorized to do so because we all have ‘lived experience’ through acquaintanceship. As Dowbiggin notes, “Over time, stakeholders such as governments, medicines, researchers, industry, schools, the media, the courts, families, and a public whose taste for treatment seems insatiable have transformed the campaign to achieve mental health into a movement that has come to mean all things to virtually all people” (Dowbiggin, 2011, p. i). Currently, through universalizing notions that we are all impacted by mental illness, and risk discourses (we can all ‘get’ mental illness), mental illness is constructed as a common threat. Thus, the binary of normal/abnormal is reframed as unitary through the often recited refrain that “one in five Canadians will develop some kind of mental illness in his or her lifetime” (Harper, 2007, p. 2). This universalization and expansion of the issue of mental health and illness away from those directly affected through discourses of risk authorizes us all to lay claim and act on madness, and works to efface the particularities of how diagnoses land on particular bodies and work as systems of governance. Not only have ‘false universalisms’ enabled “certain groups to present themselves as spokespersons for the rest” (Phillips, 2001, p. iii), Thompson and Hogget (1996) note how homogenizing social issues and social policy through universalism works to
apply the same standards, experiences, and solutions to all individuals, ignoring how ‘mental illness affects us all’ differently.

The universalizing exhortation that we are all affected, or could be affected, or ‘are all a little crazy’ effaces how the psy disciplines and their regimes of practice operationalize across the grid of social, economic, political and legal dispositifs which obscures the different ways in which ‘the crisis affects us all.’ For instance, the psy disciplines are deployed in the context of national security, such as the diagnosing of Guantánamo Bay detainees as “depressed, mentally ill, or in some way pathological” by the US military doctors overseeing them while incarcerated (Howell, 2011, p. 73). Or how schizophrenia became a Black disease in the U.S. by “drawing on a racialized logic that comes directly from the 1960’s and 1970’s, whereby schizophrenia represents both a mental illness and a threat to civilized society … [and] how civil rights-era anxieties about racial protest catalyzed associations between schizophrenia, criminality, and violence” (Metzl, 2009, p. xix). Or how Residential School Syndrome, developed as a psychological field to explain the distress of Aboriginal peoples in Canada, works as a “tactic of pathologizing these individuals, studying their condition, and offering ‘therapy’ to them and their communities [which] must be seen as another rhetorical maneuver designed to obscure” the moral and financial investments of ongoing colonization in Canada (Chrisjohn, Young & Marauen, 2006, p. 22). Thus, the universal call that “mental illnesses happen everywhere and in the same form” is deceptive (Beiser, 2003, p. 154), and disregards how mental illness is used as a strategy to govern particular types of bodies in novel ways.

3.2.4 Reifying Mental Illness through Science

Mental illness as a problem to be known and resolved through science permeates how madness will be governed. Through the Commission’s work, mental illness is often equated to, and
contrasted with, cancer and other diseases. Some consumers espouse that mental illness ‘is just like’ (or even worse than) cancer; officials argue that if mental illness were cancer, we would have sufficient health dollars to combat the disease. When people with lived experience equate their mental illness to cancer, they are lamenting the stigma and discrimination that is a consequence of their psychiatric diagnosis, and are laying claims that those with the diagnosis of cancer receive the respect, services, and supports needed. When policymakers and other officials link mental illness to ‘as like’ any other disease, the equation is intended to justify the allocation of more health dollars to be spent on mental illness. When such equivalences enter popular discourse, for example when we consider mental illness to be as like diabetes, we sustain a disease model approach to madness (Abbas and Voronka, 2014, p. 130). White and Pike note that the choice to rely on the disease model approach to madness was a (contested) decision made early by the MHCC’s Board of Directors based on the argument that it would help “lift associated feelings of shame and reassure Canadians that the experience of mental illness (directly or indirectly) is relatively common, that we are all the same” (2013, p. 245).

A disease model of mental illness also lends itself to the transformation of mental illness from a single issue to a social movement. Indeed, part of the Commission’s work is to “create a great social movement, such as those that formed around fighting diseases such as cancer and heart and stroke. This mental health social movement will ensure that mental health stays out of the shadows forever and will focus on an illness which devastates many more lives than cancer and heart disease combined” (Kirby, 2008, p. 7). This creation of a ‘great social movement,’ which the Commission often lamented as lacking, and one of their initiatives, Partners for Mental Health works to build, works to efface the longstanding work and advocacy that the consumer/survivor/ex-patient and mad movements have engaged, as social movements for over 50 years, to refute, reform and rework dominant notions and powers of psychiatry – including
speaking back to the notion that madness is like any other disease (Church, 1995; Cresswell & Spandler, 2012; Everett, 2000, LeFrançois, Menzies & Reaume, 2013; Morrison, 2009). Clearly, the social movement that the Commission identifies as needing to build, and that is so far missing, is one that above all else premises madness as mental illness, a disease that needs to be fought through science.

3.2.5 The Work of the Mental Health Commission of Canada

When the MHCC was launched, it was mandated with three key initiatives: developing a national anti-stigma campaign, generating a national mental health strategy, and the creation of a knowledge exchange centre. In February 2008, Health Canada announced the allocation of an additional $110 million over five years to be invested in a research demonstration project studying ‘mental health and homelessness’ which the MHCC administered. This study came to be known as the “At Home/Chez Soi” project, which is the central initiative under study in this thesis. An article authored by the Commission’s CEO, Louise Bradley, and David Goldbloom, current Chair of the Board of Directors (Kirby as Chair retired in 2012), is aptly titled “The Mental Health Commission of Canada: The First Five Years.” In the article, which I view as an official document, the authors provide an account of the work that the MHCC conducted between 2007-2012. Readers are presented with a particular kind of profile on what problems the Commission is targeting, what initiatives have been implemented to solve these problems, practical social and research implications of the MHCC’s work, as well as the inclusionary composition of the MHCC. The article, in particular, profiles the involvement of what has come to be referred to as “people with lived experience” of mental illness within the Commission.

In this article, the MHCC’s mandate is explained as envisioning “a society that values and promotes mental health and helps people living with mental illness problems and mental illness
to lead meaningful and productive lives” (for critiques on meaningful lives see Butler, 2004; and for a critique of productive lives see Mitchell & Snyder, 2010) (Goldbloom & Bradley, 2012, p. 222). At the five year mark, the Commission is half-way through its funding, which has a ‘sunset clause’ that sees the Commission end in 2017. The article starts by listing the three initial tasks that the Commission was enlisted to accomplish: 1) to develop a national mental health strategy; 2) to develop, implement, and evaluate a sustained and multi-dimensional anti-stigma campaign; 3) to create a Knowledge Exchange Centre “that facilitates the development and mobilization of evidence-informed knowledge … and leverages existing best and promising practices across the country” (Goldbloom & Bradley, 2012, p. 222). It is interesting to note that in summarizing these three initiatives, cross-national comparisons of how as a nation we are lagging behind other countries in implementing such ventures are made: a national mental health strategy is needed because “Canada was the only G8 nation that lacked one”; and in terms of national anti-stigma campaigns “Canada is far behind other nations in this regard” (Goldbloom & Bradley, 2012, p. 222). Because other nations have such national interventions, we as a nation are positioned as being behind. And in order to keep up with progress, and maintain metanarratives of us as a progressive and civil nation, we must replicate what other G8 nations are already doing: organize nationally against the crisis of mental illness.

In addition to these three initiatives, the MHCC has also undertaken three additional major tasks: 4) Partners for Mental Health, the “creation of a national social movement” whose development was initially funded by the Commission, but in 2012 became its own foundation; 5) The oversight of Mental Health First Aid, a training program for the general public on how to deal with mental illness; and finally 6) The At Home/Chez Soi project, for which the MHCC oversaw the design, implementation, and evaluation of the large research demonstration project, a “randomized trial of interventions for homeless mentally ill adults in five Canadian cities,”
(Goldbloom & Bradley, 2012, p. 222) often touted as the largest research project on the homeless mentally ill in the world, ever. Through these works, we can see how mental illness is solidified as a national crisis that poses risks to us all, and that we must manage this crisis unified through a variety of techniques that call on the biological sciences, progressive discourses, the science of self-discipline and regulation, mental health literacy campaigns, and more. Key to developing these regimes of practices and truths is by enjoining a variety of perspectives together through inclusionary practices which works to represent such knowledge and practice as diversified and thus all encompassing.

3.2.6 Assembling Governances

It is useful to think of the work of the MHCC as an assemblage. As Tania Li comments

*Dispositif*, apparatus, technology of government, regime of practices, assemblage – theorists have used various terms to refer to the way in which heterogeneous elements including ‘discourse, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions’ are assembled to address an ‘urgent need’ and invested with strategic purpose (Foucault 1980: 194). That purpose is the will to govern or, more specifically, the will to improve: the attempt to direct conduct and intervene in social processes to produce desired outcomes and avert undesired ones. (Li, 2007, p.264)

I focus on the work of assemblages not only as assemblages of discourse, but crucially, as assemblages of stakeholders who embody particular knowledge bases as well as identities which embody these knowledges in particular ways. This perspective seeks to unsettle and theorize the normalcy of professional groups and bodies, address the mundane of organizational work, and draw attention to the taken-for-granted structure of who finds their way to the project. Hence, not only the practice of assembling a large diversity of relevant stakeholders, but to question, why are these stakeholders assumed relevant? That is, to “highlight the resultant formation (the apparatus, the regime, the technology) which appears settled, potentially even complete.
Assemblage flags agency, the hard work required to draw heterogeneous elements together, forge connections between them and sustain these connections in the face of tension” (Li, 2007, p. 264). Through the building of the MHCC, communities of stakeholders are drawn in to reflect the scope of what mental illness means, to shape it, to perform and represent it, and work to help justify intervening on it. Through this process, subjects and subjectivities are forged, solidified, and made anew.

In exploring how diverse communities are drawn together to form particular projects from disparate locales, Li draws on Nikolas Rose who argues “that government is ‘not a process in which rule extends itself unproblematically across a territory, but a matter of fragile relays, contested locales and fissiparous affiliations’ and hence ‘inherently risky’” (Rose as cited in Li, 2007, p. 264). Li expands on Rose’s analysis to ask how assemblages are made possible: “if there is contestation, how is it manifested? If relays are fragile, what are the practices that attempt to secure them? If affiliations are fissiparous, how does this fact shape the resulting formations” (Li, 2007, p. 264)? These ‘how’ questions are often overlooked in governmentality studies, as Li notes “the practice that tends to take centre stage is problematization, as scholars examine how problems come to be defined as a problem in relation to particular schemes of thought, diagnoses of deficiency and promises of improvement” (Li, 2007, p. 264). My own immersion in the project allows an intimate vantage point of tending to how forging the conduct of the At Home/Chez Soi project was made through a myriad assemblage of stakeholders who, too, had to be governed – and govern themselves – in order to get through the project objectives. It is this work that I focus on: getting people to be included, be it through shared visions, contested interests, concession, collaboration, containing critiques, finding common ground, managing contradictions and failures, defining and developing expertise, and always reassembling (Li, 2007).
The MHCC appointed a plethora of experts in the fields of social and biological sciences, drawn from across Canada (to ensure representativeness), from a wide range of institutions (academic, community health and social services, NGO’s), occupying various standpoints (Aboriginal, Quebecois, newcomers, rural, etc.). As Rose suggests of these practices, the At Home/Chez Soi project calls upon the authors of “the truths produced and disseminated by the positive sciences of economics, statistics, sociology, medicine, biology, psychiatry and psychology . . . [who allow] new techniques for the ethical formation and capacitation of persons who would exercise authority and the deployment of a range of scientific and technical knowledges that allowed the possibility of exercising rule over time and space” (Rose, 1996a, p. 39). From this divergent range of authorized experts, the representation through multiplicities of understanding is expected to allow room for contention, deliberation, negotiation, and compromise (Ashforth, 1990, p. 13), calling on the will to truth, committed to uniting truth to power. Notable, however, is as the MHCC has progressed through the years, the initial staff of the Commission, which was awash with people with mental health expertise, has slowly through turnover been replaced with those holding other forms of expertise – fundraisers, corporate managers, government relation experts, and other biological health fields experience. Prioritizing initial professional expertise in mental health has been replaced with privileging particular corporate skills that focus on the building and running of the organization as an efficient and effective entity, rather than as a staff filled with mental health experts.

To understand these projects as tools of governance, one can see how the use of expertise produces “the capacity to generate enclosures, relatively bounded locales or fields of judgement within which their authority is concentrated, intensified and rendered difficult to countermand” (Rose, 1996a, p. 50). This tightening of professional knowledges constructs these projects as
authoritative, while working outside of official political interests, and allows for truth-making discourses on madness to appear to be generating from an independent neutral body of experts – which lends itself so well to what Rose terms ‘governance at a distance’ (Rose, 1996a, p. 46).

However, there is contestation, discontinuities, and ruptures within who are considered to be experts in the field of mental health. In the last five decades, the psychiatric consumer/survivor/ex-patient/mad movement has grown and made demands: to the right to self-governance, to the right to inclusion, to the right to exclude themselves from ‘the project.’ In this quest for self-determination, or in the quest to be let into the project, or to work outside of governing projects, the consumer/survivor/ex-patient and mad movements have sought to legitimate ourselves by harnessing our knowledges, which for so long had been troubled or left unconsidered. Our knowledge is subjugated knowledge, “disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity” (Foucault, 1980, p. 82). Yet, as I will show, the inclusion of ‘people with lived experience’ into mental health interventions is a significant departure from the social movement, advocacy, and activism work that we have undertaken. As I argue in later chapters, the development of ‘people with lived experience,’ peer identity, and peer workers is a new formation of strategic essentialism which denudes us of distinctive ideological and conceptual approaches to madness.

Through its mobilization, the consumer/survivor/ex-patient and mad movements sought to deconstruct notions of scientific expertise. By “narrativizing their dissatisfactions in the potent language of rights, they organized themselves into their own associations, contesting the power of expertise, protesting against relations that now appeared patronizing and demeaning of their autonomy, demanding increased resources for their particular conditions and claiming a say in
the decisions that affected their lives” (Rose, 1996a, p. 52). In doing so, we developed our own radical politics of expertise, a ‘counter-expertise’ that has now become professionalized in many respects (Rose, 1996a, pp. 52-53).

To be included into the assemblage as people with lived experiences premises our inclusion based on our embodied experiences, and not how we chose to make sense of such experiences. Social justice and social movement orientations are not precursors for being positioned as a ‘person with lived experience.’ Rather, I argue that collective social movement and social justice activism and advocacy have been circumvented and replaced by representational actors who are brought in to represent their individual experiences, rather than represent the knowledge base, strategies, and analytic tools that have been developed through half a century of activism. That is, our ‘expertise by experience’ as PWLE is ordered through experiences of mental illness, and not our epistemological or ontological orientations to such experience. Through current inclusionary models, our expertise is positioned as diametrically opposed to scientific expertise – we come in as knowledge of the body and not of the mind. A condition of people with lived experience is that we are brought in as bodies, with limited attention to our orientations towards how we approach the topic of madness. It is here where mental health projects suddenly sit, forced to bring those outsiders in and scramble to find workable ‘experts by experience.’

3.2.7 Experts by Experience and the Emergence of Peer Identity

My particular focus here is on the involvement of what the MHCC sometimes interchangeably refers to as consumers, peers, or people with lived experience. White notes that discussions on issues of nomenclature were debated in the early stages of the Commission’s formation on what to call people like me. Consumers initially prevailed, and “the Commission has, in its official
capacity, rejected the more political identities of ‘mad,’ ‘survivor,’ or ‘ex-patient’” (White, 2009, p. 240). The language of consumer sits well within their business model, and is used widely within mental health industry to situate us as customers of mental health services engaged in a market exchange of goods and services (which of course connotes choice and renders invisible force). On my very first day on the job, I flew to meet with a supervisor at the MHCC’s head office in Calgary. All nerves (hotels, cabs, money, flights – soon to become normalized), the discussion began with my title role as the new ‘consumer research consultant.’ The title used to make me wince more than it does now. “I don’t identify as a consumer: I identify as a survivor.” I was told back that it doesn’t matter how I identify, that my role here was to be a consumer. From that moment on, I thought of that moment every time my title was announced. And my title was announced often. It was used to make visible and explain my body as present within the assemblage, as well as the conditions under which I was meant to represent.

In the past few years, the MHCC and mental health discourses more broadly have shifted to the language of ‘people with lived experience.’ This is a turn in popular discourse: a decade ago such language was not used to signify ‘people with lived experiences of mental illness and mental health problems.’ It is a move, a turn to placing primacy our knowledge as experience: individual experiences of distress and disorder. Mad, ex-patient, psychiatric survivor, and even the language of consumer place us as bodies in relation to external forces around us: such language places us in the context of histories, of hospitals, of containment, of psy disciplines, as commodity, and business exchange. These identities connect our experiences to larger social processes and systems. In contrast, ‘people with lived experience’ contains our experiences to our bodies: it is apolitical and ahistorical language that denudes our experiences of distress as occurring within ruling relations of power. The preference that the MHCC has in using such language to describe us fits well with the contemporary individualization and ‘healthification’ of
distress (see Morrow, 2013; Chapter 3 below). Peers, and peer workers, as signifiers are different from using the language of PWLE. From the pool of PWLE, peers emerge. PWLE become peers usually when we are attached to work positions. That is, the language of peer is used when PWLE as attached to their experience come to work from that position in peer work roles. Peer marks PWLE who are working from such experience within the assemblage. Importantly, the language of ‘peer’ positions us as peer to other PWLE. That is, when we come to work in the assemblage, we are representing our peers in fellow distress and degeneracy. We are not ‘peer’ to the other professionals with whom we work. This language matters, especially because it is language that has been reworked and recently taken on new meaning, which in turn works to create new possibilities for identity, meaning, and knowledge formations.

Within the MHCC, the language of peer, people with lived experience, and consumers predominantly prevails, to the exclusion of all else. People with lived experience have become one of the central stakeholder groups that require being brought into any assembly which focuses on mental health and illness. We are often mentioned first when stakeholders are listed. This incorporation of PWLE within the MHCC is given much room in the Goldbloom and Bradley (2012) article on the MHCC’s first five years. The article notes that of the eight formal advisory groups (Science; Child and Youth; Seniors; Workforce; Family Caregivers; Service System; Mental Health and the Law; First Nations, Inuit and Métis) there is no formal advisory group for people with lived experience of mental illness. Rather, PWLE were included within these prevailing subcommittees. This is explained as being because it “reflected a desire at the outset of the MHCC for integration rather than exclusion” (Goldbloom & Bradley, 2012, p. 224). One has to wonder whether family caregivers or First Nations Inuit and Métis people feel excluded by having an advisory board devoted exclusively to their interests. Regardless, in the official academic paper, it is noted that within the MHCC “there was a feeling amongst many
people with lived experience that a separate and distinct voice of consumers was needed to completely ensure their views were heard and acknowledged” (Goldbloom & Bradley, 2012, p. 224). In response, it is documented that “The Consumer Group” was subsequently formed in September 2011. Our role (I was a part of this) was to “bring issues and guidance to the leadership team of the Commission and provide advice to the CEO and her Executive Leadership Team” (Goldbloom & Bradley, 2012, p. 224). We met in-person once, and had a few teleconferences, before we were informed that the protocol for the group would be for the CEO to be in touch with us individually, on an as needed basis. I was never consulted.

Early on in this project, the MHCC’s efforts to include people with lived experience within their mandate drew counter-efforts from the consumer/survivor/ex-patient and mad communities to insist on more than simple inclusion into “yet another moribund contribution to the current system” (Frado, 2007, p. 1). In a talk given at a Commission event, Lana Frado, Executive Director of Sound Times Support Services, a psychiatric survivor-led and run service provider in Toronto, pressed the Commission to prioritize works that would resource consumer/survivor initiatives to self-direct, rather than contribute to existing Commission priorities. She hoped that the anti-stigma campaign would move beyond fighting negative stereotypes and instead focus “on the right of consumers and survivors to live free from discrimination; that the rights of consumers and survivors under the Charter and provincial human rights legislation are enforced” (Frado, 2007, p. 1). That the Knowledge Exchange Centre activities extend beyond “clinical outcomes, provider driven research priorities, and peer-reviewed journals contributed to on our behalf by academics ‘living without mental illness’” and recognize that our knowledge needs to cease “being regulated to the discourse of ‘personal experience.’ We have analyses, theoretical frameworks, ideologies and service design and delivery mechanisms that merit investment and equitable access to research opportunities” (Frado, 2007, p. 2). In order to shift the
Commission’s mandate towards one which attends to systems of social oppression and social justice, Frado notes that the inclusion imperative cannot rest on simply absorbing our bodies of experience into pre-existing assemblages. Rather, inclusion needs to be premised on our analyses and histories of systemic advocacy and activism, and powers need to shift to allow us to hold the current mental health and social systems accountable (Frado, 2007, p. 2).

Frado’s early warning that inclusion is never enough reflects this study’s central premise: that significant change cannot come by including our bodies into the machinery of current systems praxis. As I will show, PWLE inclusion into the project implicitly and sometimes explicitly rests on an entanglement of terms of engagement. Our ‘expertise as experience’ is positioned as diametrically opposed to scientific expertise, and thus we are brought in as opposition to knowledge proper as bodies simply to be absorbed within the assemblage, rather than as holders of experiential, systemized, and official knowledges that articulate against current dispositifs of power.

3.3 Neoliberalism as Policy

Governing mental illness today is largely organized through systems of neoliberal technologies of conduct. In this section, I show how the MHCC adopts neoliberal policy and corporate structures, ideologies and governances to organize against mental illness. That is, managing mental illness requires far more than simple containment and cure methods of the past: rather, in our current times, a complex web of management strategies have emerged within neoliberalism. The most common reference to neoliberalism is as “political-economic governance premised on the extension of market relationships” (Larner, 2000, p. 5). As a departure from Keynesian welfarism, neoliberalism is associated with minimizing state responsibility and interference: “Markets are understood to be a better way of organizing economic activity because they are
associated with competition, economic efficiency and choice” (Larner, 2000, p. 5). Neoliberal
governments focus on enhancing economic efficiency, leading to deregulation and privatization,
and politicians and policy makers are understood as key players. The governance of mental
health and illness is a state function and responsibility, yet under neoliberalism market models
are drawn upon to make social policy more efficient by drawing on audit culture, evaluation,
accountability, and cost-benefit analysis.

The MHCC, registered in March 2007 as a non-profit corporation, adopted a corporate business
model to structure its mandate:

[The MHCC] has since drawn heavily on social marketing frameworks to identify the
organization’s specific targets and objectives; to develop a strategic business plan
outlaying the financial viability of specific projects directed toward meeting those
objectives; to establish measurable outcomes and success indicators within strategic
projects in order to demonstrate efficiency and efficacy; and to market a singular and
unified message to the public about the causes/costs/effects of ‘mental illness,’ and the
current mental health ‘crisis’ in Canada. (White, 2009, p. 228)

Developing a commission that works at arms-length from the government to provide sound,
objective advice to it, moves to “create a distance between the decisions of formal political
institutions and other social actors” (Rose, 1996a, p. 53). This arms-length status of the
Commission primarily as a body that is to provide advice to the government positions the
Commission as an objective entity that emphasizes strategies that are “evidence based and
evaluated,” whose initiatives are measured, and strategically focused (MHCC, 2007, p. 30), and
which draws together “dominant scientific and social scientific knowledges about the
cause/nature of mental illness with political and economic concerns of national health,
productivity, citizenship, and work” (White, 2009, p. 233).

Because the MHCC is federally funded, it is financially accountable to the government and as a
corporation is structured to be accountable “through evidence of sound business planning,
economic frugality and reliable indications of success” (White, 2009, p. 244). As an entity, “The MHCC is funded annually in the amount of $15 million by the Federal Government through Health Canada, the federal health ministry, but exists at arms’ length from its funder. Nevertheless, it is accountable each year to Health Canada, with a business plan for the coming year and a financial audit” (Goldbloom & Bradley, 2012, p. 225). The Commission thus must provide “clear and justifiable rationale regarding how its objectives are identified and prioritized; how those objectives and priorities can be operationalized as a strategic business plan; how evaluative measures, such as benchmarks and success indicators are to be established; and ultimately how outcomes are measured and interpreted” (White, 2009, p. 244). However, White argues that this “seemingly tidy, focused, linear model – the business model – when applied to the profoundly complex issue of mental illness, is especially perplexing” (White, 2009, p. 244). White argues that relying on a business model to the phenomenon of madness and mental illness may indeed further restrict the possibilities for the meaningful change in the ways in which madness is conceptualized, responded to, and managed, and that “the well intentioned (if not very new or creative), neoliberal social justice mandate of the MHCC is significantly undone by its remarkably conservative corporatization” (White, 2009, p. 244). Thus, the rules and ‘common sense’ of corporate organization governs what knowledge and action is made possible about madness.

3.3.1 Neoliberalism through Ideology/Discourse

Stuart Hall and others have noted that neoliberalism works not just as a system of ideas that are constituted and executed only on the political terrain of the state (Larner, 2000, p. 9). Rather, neoliberalism requires and mobilizes ‘stakeholders,’ subjects from a diversity of seemingly conflicted social positions who are called into being invested in reform, efficiency, and change
based on neoliberal ideals such as the humanist liberal individual’s right to choice. Thus the diverse make-up of assemblages, Hall argues, explains how neoliberalism works as a “struggle to gain ascendancy over the entire social formation, to achieve positions of leadership in a number of different sites of social life at once, to achieve the commanding position on a broad strategic front” (Hall, 1988, p. 52). Bringing in, and having buy-in from a diversity of stakeholder groups is thus key to creating formations built on consent, rather than coercion. While stakeholders may be divided on what they think are the root problems of mental illness and mental health care in Canada, together they work together united under the rubric that there are problems that need to be fixed.

This work of assembling diverse subjects from a range of social locations to participate in the making of the MHCC’s priorities is illustrated by one of its first undertakings: a broad national consultation which took place between October 9-17, 2007 in six Canadian cities: Toronto, Saint John, Halifax, Vancouver, Edmonton, and Winnipeg. The subsequent reports produced from these consultations, “Moving Forward Together: Stakeholder Perspectives on the Priorities of the Mental Health Commission of Canada,” notes how invited participants included: “people who have experienced mental illness; their family members; formal service providers; hospital personnel; community groups; regional planning bodies; government; police. These participants also represented different life stages, ethnocultural groups, Aboriginal communities, as well as a variety of perspectives” (MHCC, 2007, p. 2). The point here is that the Commission is positioned to act as an intermediary between governments (federal, provincial/territorial, and municipal) and both public and private sectors and communities, and in order to ‘move forward together,’ must enjoin a variety of subjects across the grid of power into the project. The game cannot be
played through coercion alone. Through inclusion, participation and diversity, governing through consent is made possible.

How much flexibility there is in the mandate and what is produced through these broad stakeholder consultations is another matter. As White notes, “given that the federal government established the priorities for the MHCC long before the organization was in place, and before stakeholder consultations could even begin, there was little opportunity for new or alternative priorities to be established in response to community feedback. In other words, the express bus was fueled up and well en route, destinations determined, before passengers were invited to ride along” (White, 2009, pp. 226-227). Regardless of outcomes, it is noteworthy how neoliberalism as an ideology/discourse is not simply monopolized by hegemonic political players, but also works to constitute marginalized identities with political agency who “mobilize around particular collective identities in order to represent their interests and intervene in the process of restructuring” (Larner, 2000, p. 11). This constitutes us all as political players in neoliberal agendas, whether we are supporting or refuting the shifts that are occurring. This means that neoliberalism as ideology/discourse works as a “complex and hybrid political imaginary, rather than the straightforward implementation of a unified and coherent philosophy (Larner, 2000, p. 12).

Further, in these welfare state restructuring processes, those of us who are often resisting or affected by such measures are called in to consult, inform, and negotiate with the ‘top down’ arrangements by revealing our ‘bottom-up’ investments: “Here we can witness the ‘reversability’ of relations of authority – what starts off as a norm to be implanted into citizens can be repossessed as a demand which citizens can make of authorities” (Rose, 1996a, p. 59). And thus, neoliberalism as ideology/discourse forces us to acknowledge that “power is productive, and that
the articulations between hegemonic and oppositional claims give rise to new political subjectivities and social identities which then enter into the ‘discourse of restructuring’” (Larner, 2000, p. 12).

3.3.2 Neoliberalism as Governance

Governmentality under neoliberalism, often referred to as ‘advanced liberal’ governments, distinguishes between government and governance, for while “neo-liberalism may mean less government, it does not follow that there is less governance. While on the one hand neo-liberalism problematizes the state and is concerned to specify its limits through the invocation of individual choice, on the other hand it involves forms of governance that encourage both institutions and individuals to conform to the norms of the market” and society (Larner, 2002, p. 12).

The MHCC’s implementation fits well with Nikolas Rose’s assertion that we are now governed by way of ‘advanced liberal strategies,’ governance that is executed at arms-length, appearing non-coercive and gentle in its application: a prime example of what he calls ‘governing at a distance’ (Rose, 1996a, p. 43). Thus, while appearing as a slight of hand, enjoining science with social science, cross-community consultation and a diversity of inclusion the MHCC should be understood as a novel strategy working within neo-liberal governance which provides a new slant and tactic for attacking the age-old problem of madness. As Rose notes, “neo-liberalism does not abandon the ‘will to govern’: it maintains the view that failure of government to achieve its objectives is to be overcome by inventing new strategies of government that will succeed” (Rose, 1996a, p. 53). Or as Martinot and Sexton note, government is never the problem. Rather, with more arms-length government through governance “remedies can always be found within
liberal capitalism: from psychological counselling, moral and scientific education, legal prohibition, or even gene therapy” (Martinot & Sexton, 2003, p. 178).

This new approach of governance through distance is precisely the hope and promise that the MHCC evokes. It embodies the quasi-autonomous non-governmental organizations that have proliferated under neoliberal governments: harnessing methods that work to conduct the conduct of its mad and sane populations alike through strategies, technologies and techniques of government “that create a distance between the decisions of formal political institutions and other social actors, conceive of these actors in new ways as subjects of responsibility, autonomy and choice, and seek to act upon them through shaping and utilizing their freedom” (Rose, 1996a, pp. 53-54). This dissertation shows the many ways in which the work of the MHCC follows this governing through a distance. The research, knowledge exchange, national strategies, public education, and campaigns that the MHCC produces is all work built to advise us: as a nation, as people ‘all affected by mental illness,’ and as distressed individuals. It is left to our work to take these official knowledges and implement them within our local governments, local community service providers, family members, or within our very own souls. In the next section I show how Housing First as a program model to house ‘the homeless mentally ill,’ governs through choice, freedom, and responsibility, rather than traditional and overtly coercive models. And finally, through my exploration of peer identity and peer work, I show how people with lived experience, through inclusionary and participatory practices, are now authorized through authenticity, experience, and ‘shared commonality’ and become something new: transformed into agents brought in to govern ourselves and ‘those like us.’

Thus, taking into account the ways in which neoliberalism works through policy, ideology/discourse and governmentality, a more nuanced picture emerges. It shows how state,
discourses, and selves are co-constituted and “emerge out of a multiplicity of political forces always in competition with one another, producing unintended outcomes and unexpected alignments. Moreover, the emergence of new political projects is never a complete rupture with what has gone before, but rather is part of an ongoing process involving the recomposition of political rationalities, programmes and identities” (Larner, 2000, p. 16). My research traces the ways open strategies of governance become authorized through technologies of inclusion, knowledge production, wellness models, management and administration, and importantly, how such technologies have also reworked ‘people with lived experience’ to harness new identities as ‘peers’ and ‘peer workers.’

3.4 Part 2: Managing the Chronically Homeless Mentally Ill: The At Home/Chez Soi project

It seems ironic that in desperately unequal times, when neo-liberal regimes are cutting programs, particularly for women and more particularly for women of colour, an expansive industry of evaluation and accountability firms is flourishing, funded handsomely by public subsidies, documenting the conditions under which state interventions are (and more often not) ‘working.’ In a culture of gendered austerity and then racialized and classed punishment, psychologists are being recruited, I fear, to create a science of banal dispossession – to engage in the systematic collection of evidence that demonstrates (usually) that State programs don’t make up for historic and cumulative oppression, legitimating the slashing of the safety net. (Fine, 2012, p. 4)

The context in which I explore the emergence, performance, and performativity of peer work is within the At Home/Chez Soi research demonstration project. Understanding the main components of this project, as well as how they are situated within large-scale neoliberal governance, is key to understanding how and why peer identity and peer work unfolded in contested, contradictory, and confusing ways. Peer workers are usually brought in to support and attend to ‘the mentally ill’ in mental health service systems. That is, the most common way that peer work is deployed is through peer support work. In this role, we are directed towards governing each other: we are meant to draw on our own ‘lived experiences’ of distress to support
other abjected bodies, as well as offer advocacy and recovery-oriented interventions. However, because the At Home/Chez Soi project was a large national mental health research intervention, in order for the project to be positioned as inclusive, peer participation meant that peer work roles were extended beyond providing mental health services and support. That is, to be able to lay claim to peer participation within At Home/Chez Soi, peer work roles had to permeate all echelons of the project: not only within mental health service teams, but also in administrative, research, and community organizing roles. As I show in later chapters, developing and sustaining peer work roles that moved beyond peers managing each other created contradictions: peer work roles such as peer researchers, peer advisory roles, peer organizers and facilitators worked fine when we were working amongst our fellow ‘peers’: but when we made moves to use our knowledge base to generate knowledge production, systems change, and intervene on the project itself, peer workers had minimal impact. That is, when we turned away from governing each other, and attempted to govern the larger project structure, our effect was minimal and required managing.

Vancouver’s downtown eastside is an exceptional site as a concentrated space where drug use, homelessness, and mental illness are highly concentrated. Vancouver’s rise as a world class city is contrasted by this site of exception, which rubs up against the increasingly gentrified Vancouver waterfront (Culhane, 2009). The neighbourhood acts as a spectacle of degeneracy, in particular for its high concentration of homeless Indigenous peoples, as the space itself appears as an unavoidable visual and visceral reminder of the ongoing impacts of continued colonization in Canada. One cannot confront the site without asking how it is that Indigenous peoples have come to be homeless, thus evoking the violent colonial legacy on which this country was built, and how it remains sustained. Countless interventions, some progressive, others aggressive, have been targeted in Vancouver’s downtown eastside in an effort to fix this site of exception.
This space was at the forefront of the government’s mind as Vancouver prepared itself for the 2010 Winter Olympics hosted in Vancouver. The city was set to become an international travel destination, and a myriad of housekeeping tasks faced the city, one especially being what to do with homelessness in general, and the downtown eastside in particular. The Federal government consulted with national leaders to discuss options for fixing this problem site. During these negotiations, it was suggested that this opportunity be expanded nationally, and instead of it just being a housing and service program, that the intervention come in the form of an evidence-based research project to collect proof on how to best house the homeless mentally ill across Canada. Thus the origins of the project were to intervene on the downtown eastside in order to ‘clean up’ the story that the site speaks to: of Canada as a nation negligent of its poor, mad, Indigenous, and homeless populations. That is, part of the work that the At Home/Chez Soi project does is offer an intervention which not only shows that we continue to try to solve the problem of homelessness, but also attempt to clean up a city-space in preparation for the international spotlight that the Olympics brings. For Canada to maintain its reputation internationally as a nation with a strong social safety net, as nativist White yet multicultural, and a champion of health and safety for its citizenry, we needed to quickly clean up a site of abjection before the city was launched, through the Olympics, into international spotlight. The program model that was chosen to be implemented and studied was the Housing First program model, a housing and mental health service model that is based in the principles of choice, responsibility, and finding privatized means of solving the social problems of homelessness.

Governmentality studies have shown that when programs are implemented to provide help to clients, but the problem persists, marginalized individuals can then be blamed for not doing their required work to self-govern: the resources are there, the steps are in place, the science to follow (Rose, 1996a). What is lacking is the uptake. Once the truth of the problems/solutions are
revealed, all that is left is to self-manage. In the past, disadvantaged subjects were understood as the underserving poor because of their personal shortcomings, an argument that “draws veracity from liberal capitalist imperatives of free exchange – those who are out of work or insufficiently employed are blamed for failing to realize the freedom to sell their labour” (Willse, 2010, p. 165). Under neoliberalism, individuals are re-made citizens through post-social programs that require (acquired) agency through choice, responsibility and self-management by activating subjects to learn to make the right choices and rejoin into the social contract. Or, coming at it in simpler terms, the marginal mad must submit to the “arts of self-management: keep your appointments, take your medicine, don’t get drunk or violent – or you will lose your place in the project” (Rose, 1996b, p. 14). The common good is doing its job, all that is left is for the marginalized to self-govern.

In their book *Governing the Present*, Miller and Rose argue that in the shift from social welfare to neoliberal managements of state, discourse and self, the hitherto passive recipient of benefit care is reenergized into “an individual whose citizenship is active” (2008, p. 82). Rose and Miller describe this shift from care to choice as substantiating the neoliberal individual:

No longer was citizenship construed in terms of solidarity, contentments, welfare and a sense of security established through the bonds of organizational and social life. Citizenship was to be active and individualistic rather than passive and dependent. The political subject was to be an individual whose citizenship was manifested through the free exercise of personal choice amongst a variety of options … Programmes of government were to be evaluated in terms of the extent to which they enhanced that choice. And the language of individual freedom, personal choice and self-fulfillment came to underpin programmes of government articulated from across the political spectrum, from politicians and professionals, pressure groups and civil libertarians alike. (Miller & Rose, 2008, p. 48)

Importantly, this paradigm of individual choice drew support not just from ‘public enemies’ such as fiscal conservatives but from “feminists, radicals, socialists, sociologists and others” (Miller &
Rose, 2008, p. 82), and the wide-ranging field of management experts and programmes that have emerged under neo or ‘advanced liberal’ societies range from governing behaviours, to lifestyles, to souls. Central to this shift is the focus on risk, responsibility, and choice: “Through this loose assemblage of agents, calculations, techniques, images and commodities, individuals can be governed through their freedom to choose” (Miller & Rose, 2008, p. 82). In what follows, I show how the At Home/Chez Soi project through the Housing First program model draws on such open forms of governance which are premised on choice, citizenship, and responsibility, and neoliberal governmentalities.

3.4.1 The Project of Building the At Home/Chez Soi Project

The At Home/Chez Soi project was a five-year, $110 million research demonstration project funded by Health Canada and administered through the MHCC. The first year of At Home/Chez Soi project funding (April 2008-March 2009) was spent developing a research design, circulating Requests for Proposals, consulting with various stakeholders across the chosen 5 sites (Vancouver, B.C.; Winnipeg, MB; Toronto, ON; Montreal, PQ; Moncton, NB), and selecting the winning proposals from the sites that would constitute the local players (local research teams, local service providers, local housing teams, local government partnerships, communities including Indigenous peoples and people with lived experience) that would implement the study in each of the sites. During that first year of project development select researchers in collaboration with funders decided that the research design would be a

*pragmatic, multi-site field trail of the effectiveness* of Housing First with concomitant economic and qualitative process evaluations. It is intended to provide policy-relevant evidence about whether a complex housing and support intervention works under real life conditions in five Canadian cities. This demonstration project includes funding for the implementation of the intervention through contracts with existing service agencies and rent supplements for participants. (Goering et al., 2011, p. 3)
The research design allowed for the project to randomize “approximately 2500 participants, stratified by high and moderate need levels, into intervention and treatment as usual groups. Quantitative outcome measures are being collected over a 2-year period and a qualitative process evaluation is being completed” (Goering et al., 2011, p. 1). The research outcomes focus on quality of life, housing stability and social functioning of participants, as well as economic analyses.

The basic research design involved, prior to randomizing a participant, determining through an assessment tool whether they were “High Needs” (psychotic disorders, manic and hypomanic episodes) or “Moderate Needs” (depressive episodes, anxiety disorders). This was done through the administration of a fifteen minute instrument called the Mini International Neuropsychiatric Interview (MINI), a “short, structured diagnostic interview that was developed in 1990 by psychiatrists and clinicians in the United States and Europe for DSM-IV and ICD-10 psychiatric disorders” (Goering et al., 2011, p. 11). Those determined in fifteen minutes to be high needs were thus allocated into Housing First and Assertive Community Treatment teams or Treatment as Usual (TAU). Those determined to be moderate needs were randomized to Housing First and Intensive Case Management or TAU (Goering et al., 2011, p.3). A button on a computer was pushed to determine whether the participant would be in the intervention or control group. Some of the participants received housing and services, while the others did not. Both intervention and control group participants were followed by research teams for twenty-one months of quantitative questions, and a baseline and eighteen month follow up qualitative interview. The main objectives of this intervention were to 1) study whether Housing First leads to better outcomes than TAU for homeless individuals with high to moderate needs; 2) to examine the cost effectiveness of Housing First in comparison to TAU; 3) to examine the correlates of different trajectories such as housing stability, mental and physical health and employment over
time and; 4) To identify what modifications to Housing First need to be made to “effectively serve particular sub-populations (e.g. Aboriginals, ethnic groups, those living in congregate or rural settings)” (Goering et al., 2011, p. 3).

While the basic research design was held consistent across the five cites (to allow for consistent cross-site comparisons) and the foundational structure of the research design (as a randomized controlled trial with a Housing First intervention) was not flexible, each local site research team were given the option of an additional third arm in their local setting, to address local site interests and “in order to ensure local buy-in” (Goering et al., 2011, p. 3). The third-arm application allowed for some room and flexibility within each site, to tailor this macro project to fit the desires of local research and community interest. In Vancouver, the third arm implemented a congregate building and studied results against those living in scattered site dwellings. In Winnipeg, the third arm investigated “the use of traditional and spiritual approaches and how it affects the outcomes of participants,” and this site itself was focused on learning “what works and does not work for the Aboriginal population” (MHCC, N.D. a, p. 1). In Toronto, the third arm focused on learning how to best “address the needs of people from various ethnic and racial communities” by providing ICM service delivery from Across Boundaries, an ethno-culturally specific service agency (MHCC, N.D. b, p. 1). In Montreal, the third arm “investigated the success of a program that supports people who are ready to work” called Independent Placement and Support (MHCC, N.D. c, p. 1). And in Moncton, the smallest site and smallest participant recruitment sample (200 participants, and this the only site where all the intervention group participants received the same services, from ACT), the third arm investigated “the outcomes of people living in rural areas” as well as issues specific to small cities (MHCC, N.D. d, p. 1).
Over the course of the four-year implementation of this large project, some variation from the original design inevitably occurred. For instance, it was originally planned to have the participants followed for twenty-four months with quantitative questions, but that was shortened to twenty-one months because of some sites’ delayed recruitment. While the initial plan was to involve 2500 participants in the project, the sample ended up being 1030 participants in the intervention group and 980 in the control group. And while the core principles of the research design held firm (randomized controlled trial, studying the Housing First intervention), flexibility was needed throughout the four years to deal with on the ground issues, incidents, and other variables.

3.4.2 Housing First

The chosen housing and service intervention under study was the Pathways Housing First model, which is also sometimes referred to as a philosophy. When I first heard about the Housing First model, it sounded better to me than a lot of the more regulatory ways in which homeless and/or mad people have to work to access housing. The dominant system of care in Canada and the United States, often referred to as the Continuum of Care or ‘staircase’ model, requires the completion of several program components before one can receive permanent housing: usually outreach, followed by treatment (to either get people off street drugs, start them on psychiatric drugs, or both), then transitional housing which is meant to “enhance clients’ ‘housing readiness’ by encouraging the sobriety and compliance with psychiatric treatment considered essential for transition to permanent housing” (Tsemberis et al., 2004, p. 651). Thus the Continuum of Care model requires overt governance of an individual’s behaviour, abstinence from street drugs, compliance with psychiatric drugs, and skills training on how to ‘properly live’ learned within transitional settings (which often have strict disciplinary measures that regulate when to wake,
bed, eat, and restrict sexuality). If a person does make it through these hurdles and acquires permanent housing, often in congregate supportive housing sites, this housing can still be revoked as “most programs have rules that restrict clients’ choices and that when violated are used as grounds for discharging the consumer from the program. For example, despite having attained permanent housing, clients who relapse and begin to drink mild or moderate amounts of alcohol, may be evicted if the program has strict rules about sobriety maintenance” (Tsemberis, Gulcur, & Nakae, 2004, p. 651). These overtly disciplinary social service models of welfare provision have been referred to as acting through a ‘tyranny of kindness’ (Funiciello, 1993), “signalling the coercive nature of paternalistic programmes that demand submission to reform protocols in the name of the client’s own good” (Willse, 2010, p. 166).

The Pathways to Housing organization, which started in New York City but now has affiliates across the U.S. is often credited as having ‘cleaned up New York City streets.’ Founded in 1992 by Dr. Sam Tsemberis (a primary consultant for the At Home/Chez Soi project), he developed the Pathways Housing First model. While there are a few different models of Housing First, ongoing references here to Housing First are all referring to the Pathways to Housing Housing First model. Housing First counters tradition models of housing people without homes. The Housing First model “is based on the belief that housing is a basic right and on a theoretical foundation that includes psychiatric rehabilitation and values consumer choice” (Tsemberis et al., p. 651). What follows is a description of how Pathways to Housing provides their services:

Pathways encourages consumers to define their own needs and goals and, if the consumer so wishes, immediately provides an apartment of the consumers’ own without any prerequisites for psychiatric treatment or sobriety. In addition to an apartment, consumers are offered treatment, support, and other services by the program’s Assertive Community Treatment (ACT) team. ACT is a well defined community based inter-disciplinary team of professionals that includes social workers, nurses, psychiatrists, and vocational and substance abuse counselors who are available to assist consumers 7 days a week 24 hours a day (Tsemberis et al., 2004, p. 652).
Within this Housing First model, housing and service provision are considered separate domains, and “consumers in the program can accept housing and refuse clinical services altogether without consequences for their housing status” (Tsemberis et al., 2004, p. 652). This means that consumers can get housing but refuse program psychiatric interventions. In this way, “Housing First represents a potentially radical break from medicalized models” (Willse, 2010, p. 166). In the At Home/Chez Soi project, participants receiving ACT services were required to make contact with a member of the team weekly, and members of an ACT team also included at least one full time peer support worker alongside the usual suspects in a clinical team. Here, we see how peer support workers are key components to the assemblage of workers managing the ‘homeless mentally ill.’ Thus “immediate access to independent housing, the separation of housing and support, and the highly individualized support services provided by multidisciplinary teams (based on the idea of harm reduction) may be seen as the defining features of the [Housing First] model” (Hansen Löfstrand & Juhila, 2012, p. 48).

Within this model housing choice is centralized. Emphasized in the model is client choice of housing unit, neighbourhood, and what kind of help they receive and from whom. Importantly, rather than relying on government funding dollars to provide the infrastructure for building more supported and subsidized housing units, the housing component within Housing First comes in the form of a rent subsidy that is attached to the client, and moves with them. While clients had a reasonable choice of where they would like to live, including supportive housing buildings, most At Home/Chez Soi project participants chose private market apartments. That is, their rent supplements subsidized their choice of market rent scattered-site apartments as opposed to the supportive or subsidized congregate housing offered by traditional government-funded housing buildings. The At Home/Chez Soi participants that were part of the intervention group were signed up for welfare or disability in their province, and thirty percent of their cheque was
required to go towards rent. The project provided a ‘top-up’ rent supplement, ranging from $200 to $600 a month, depending on the city and average market rents. It’s important to note that Housing First is a mental health intervention, thus housing is understood as a part of the treatment modality. This study thus draws on health and not housing dollar investments, and those homeless without mental health issues are excluded from this project.

Some longitudinal studies on the effectiveness of the Housing First model as an intervention when compared with other provider models has been conducted in the United States and Europe (Gulcur, Stephanie, Shinn, Tsemberis, & Fischer, 2003; Padgett, Gulcur, & Tsemberis, 2006; Atherton & McNaughton-Nicholls, 2008). One U.S. twenty-four month study involved randomizing 225 participants, approximately half into continuum of care models, and the other half into Housing First. The study found that Housing First participants had a high eighty percent housing retention rate, with no significant differences in psychiatric symptoms or alcohol and drug use (Tsemberis et al., 2004, p. 654). Note that this study is very different from the At Home/Chez Soi project, in that all participants received some sort of housing and service delivery component. Other studies have shown that “the program ends chronic homelessness for 85 to 90 percent of participants (in contrast to a 45 percent success rate for programs requiring an individual to ‘get clean and sober’ and take psychiatric medicine prior to receiving housing)” (Kauffman, 2012, ¶ 26). Christy Respress, Executive Director of Pathways to Housing DC, says that the reason for Housing First’s success has been the research that has backed up programs results. Support for the model came after a five-year research study that showed participants had “higher retention rates, improved long-term housing outcomes, and decreased time in jail, emergency rooms, and hospitals – ‘all three of which are incredibly expensive,’ says Respress – compared to participants in programs that require people to accept treatment before being offered housing. These results garnered bipartisan political support for the program” (Kauffman, 2012, ¶
Indeed, in the U.S. “in just the last several years, Housing First has moved from a marginal model to one promoted by [the U.S. Department of Housing and Urban Development], the Interagency Council on Housing and the US Council of Mayors, a consortium of municipal governments” (Willse, 2010, p. 166). Respress viewed evidence based data as a central determining factor in garnering support for the Housing First model: “Since there is not a belief in the US that there is a ‘right’ to housing, the data is important in making the argument for this kind of investment” (Kauffman, 2012, ¶ 29).

The general appeal of the model lies in how it centres housing as a human right, and that philosophies of client choice, responsibility, and the aim of recovery are viewed as ‘good’ and progressive compared to more custodial models of care. In this way, the support for Housing First is “unexpectedly benefitting an abandoned and usually despised and degraded population” (Willse, 2010, p. 172). But Willse argues that in order to comprehend what made the Housing First model possible in the U.S., one has to understand “the economic dimensions of the invention of chronic homelessness” (2010, p. 168). Further, Hansen Löfstrand and Juhila note, the Housing First “model has become regarded as a more economically viable and efficient solution than other models. From this perspective, it is limited economic resources, rather than the needs and wants of homeless individuals, that motivates the policy change” (2012, p. 51). Thus the appeal of Housing First must be understood as fitting into neoliberal ideals of individual risk, responsibility, and choice; greater individual (housing stability) and community (safety, surveillance and containment of abject bodies) outcomes; and importantly, better cost efficiencies in the age of austerity.
3.4.3 The Business of Homelessness as Economic Investment

While Housing First allows governance through freedoms, the At Home/Chez Soi project should also be understood as a biopolitical project that contributes a novel approach to governing homelessness under neoliberalism: through economic investments. If “biopolitics describes a political analysis of population dynamics, such as patterns and rates of birth, illness and death, in relation to material resources” (Willse, 2010, p. 157), the At Home/Chez Soi project, especially through its quantitative research toolkit, allows us to know homeless populations through longitudinal study. Rendered known are birth, death, and illness rates (how people died, how many gave birth, what illnesses and treatments were received); what people eat and where they get their food; where and how people live; how much and where people get their money; what resources participants draw on (justice, health, welfare, veterans); how they relate to their surrounding communities (libraries, churches, community centres, and drop-ins), and so on.

In his important article “Neo-liberal Biopolitics and the Invention of Chronic Homelessness,” Willse argues that homelessness initiatives under neo-liberalism have shifted from being social to economic programmes that intervene by governing not primarily individuals, but rather refocus on entire populations through “economic analyses of population dynamics,” what he terms the ‘biopoliticization of housing insecurity’ (2010, p. 158). The At Home/Chez Soi project can be seen as a social experiment that allows for us to come to know this population through statistical accumulation, which in turn allows the government in its financial administrative role to be guaranteed that “this problem unfolds in what are taken to be economically efficient and productive ways” (Willse, 2010, p. 175). The making of the At Home/Chez Soi project thus was made possible because of the neo-liberal restructuring needs of understanding homelessness not just at an individual level, but at a population level to enable economic analysis. Hence how an
assemblage of government, academic, service providers, peers, and more came together to forge across this national project through the productivity of biopower.

Willse shows how homelessness programs have adapted business model approaches to enclose the problem of homelessness. Rather than focus on the structural conditions that produce homelessness, or the individuals that experience it, within neoliberalism “the problem of chronic homelessness becomes a problem of inefficient use of resources. The solution becomes better management of social welfare administration through the application of business principles” (Willse, 2010, p. 171). In this transition from social welfare states to social investment models, through such programmes of freedom such as Housing First, the locus of governance shifts from overt concerns of individual governance to population management through economic statistical analyses and the application of business principles. This substantiates a fundamental change in approach to social problems, by “not simply subjecting social programmes to economic logics, but by transforming social programmes into economic industries” (Willse, 2010, p. 174). In this way, the project contributes new meta-data on how to best economically govern the problem of homelessness through cost-effective measures that are set to prove that it makes better business sense to house people than to leave them homeless.

The At Home/Chez Soi project reflects how “the management of housing insecurity is itself an economic enterprise” (Willse, 2010, p. 174), bringing millions of dollars to five cities in Canada, granting researchers large funds, funding thirteen service provider teams, bringing money to private landlords, hiring peers, generating well-paid community-oriented jobs – all contributing to what INCITE (2007) calls the ‘non-profit industrial complex.’ The non-profit sector relies on populations in need of intervention to produce a vast amount of economic activity: the social service sector, social/scientists, the MHCC proper all rely on the marginalized to create industry,
where the troubled “become the raw material out of which studies and services are produced” (Willse, 2010, p. 174). I’ve had many conversations about this dependency with colleagues, and all reflect that they would gladly lose their job once the problem is solved. Of this I have no doubt. However, under this reorganized neoliberal way of doing the business of homelessness, again instead of focusing on dismantling the structural causes that proliferate marginality, we rather turn to implementing business investment models that ensure the sustained management of such populations, and our jobs seem more secure than ever. Crucially, peer workers are increasingly becoming central players in this business of mental health and homelessness management.

The tension for me is one of understanding Housing First as a better model than what currently exists, yet recognizing that it sits uncomfortably for housing activists and advocates. Or, it is about knowing that this model benefits both homeless people and the neoliberal economy.³ This tension arises from a seemingly “inherent contradiction in that they serve both the economic needs of neo-liberal cities and the needs of a vulnerable population. But there is no contradiction. Chronic homelessness programmes serve the economy twice over: first by removing an economic obstacle [the costs that homeless people incur the state by being homeless] and then by investing in a non-profit industry of population management” (Willse, 2010, p. 174). The positive possibilities of widespread adaptation of the Housing First model – people getting housing through a freedom model – are made possible by mobilizing “neo-liberal discourse of cost and efficiency to advocate successfully what humanist or ethical discourses have failed to

³ Critiques of the Housing First model include how it relies on private housing, which circumvents government responsibility for investing in affordable housing and developing a national affordable housing strategy; that it situates mental illness as the cause of homelessness, rather than poverty; and that the ‘choice’ paradigm in the model is able to operate because other laws are already in place which revoke the rights of those diagnosed mentally ill to refuse treatment, such as through Ontario’s Community Treatment Orders.
do” (Willse, 2010, p. 171). The At Home/Chez Soi project is able to draw on its population data to advocate for housing for the homeless precisely because it fits within neo-liberal restructuring. The danger felt by some is how this solution works within private business models, which retrofits a social problem caused substantially by neo-liberal capitalism into an economic problem that can be contained through population managements. Through this process, new populations and subjects are made, including the emergence of the ‘chronically homeless mentally ill’ as a population in need of economic management.

3.4.4 The ‘Chronically Homeless Mentally Ill’ and Neoliberal Biopolitics

The emergence of ‘the chronically homeless’ as both a population and a subject is a recent phenomenon. The United States Interagency Council on Homelessness defines ‘the chronically homelessness’ as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years [italics added]” (Willse, 2010, p. 155). Of note is how in the very definition of the chronically homeless, it is assumed that such a body holds a ‘disabling condition’ that is tied to their state as homeless – here disability by definition is a causal factor of homelessness. Similar criteria in the At Home/Chez Soi project was used to ensure that the project was indeed recruiting and targeting ‘the chronically homeless mentally ill,’ a specific category defined against the more general homeless body, which included couch-surfing and transitional housing such as shelter stays counting towards qualifying as experiences of homelessness. Distinguishing sectors of the homeless body through stratification is necessarily in order for interventions to match their program intention to their program outcomes: proof that such interventions are indeed servicing the populations that they are funded to assist. Continued funding requires that programs prove that they are capturing their intended target populations to
ensure that cost-efficiencies and efficacies are being made. This is because sectors of the homeless body, especially the chronically mentally ill, are understood as producing more cost across social services systems (health, justice, emergency services), in contrast to others who are simply caught in transient poverty.

Willse notes that programs such as Housing First, which explicitly target the chronically homeless mentally ill – those who are understood as ‘hard to house’ – can be interpreted as “surprising considering that those categorized as chronically homeless are disproportionately men of colour who actively consume drugs and alcohol and lack close family ties. This population, demonized by politicians and media as the ‘underserving poor,’ is more commonly barred from social service agencies and ‘housed’ in prisons and jails” (Willse, 2010, p. 157). But importantly, Willse’s analysis shows how, under neoliberal tactics of the privatization of social problems, “the invention of chronic homelessness can be understood as effecting a ‘biopoliticization of housing security’ – the development of technologies of governance that do not depend upon disciplining the individual human subject, but that rather arise out of economic analyses of population dynamics” (Willse, 2010, p. 158). This “transition from the social welfare state to the social investment state” (Willse, 2010, p. 173) has given rise to the chronically homeless as objects of economic investment that circumvent the requirement for such subjects to govern themselves into responsible selves.

To fully contextualize Willse’s argument, we must recall that Foucault marked the 19th century emergence of biopolitics as modern states moved to manage populations through strategies of fostering respectable and productive bodies while divesting in degenerate abject bodies: a process of “making live and letting die” (Foucault, 1997, p. 247). Biopolitics harnesses both techniques that discipline and regulate individual bodies, as well as techniques “which brings
together the mass effects characteristic of a population, which tries to control the series of
random events that can occur in a living mass, a technology which tries to predict the probability
of those events … or at least to compensate for their effects” (Foucault, 1997, p. 249). Under
biopower, what Foucault calls state racism is used to stratify the population, and distinctions
between productive and regressive bodies are made, a way of disentangling the groups that exist
in a population to determine the break between what should live and what should be left to die
(Foucault, 1997, pp. 254-255). Thus, “biopolitics deals with the population, with the population
as a political problem. As a problem that is at once scientific and political, as a biological
problem and as power’s problem” (Foucault, 1997, p. 245).

Through neoliberalism, biopower has shifted the ways in which technologies of the self and
populations work on respectable and degenerate bodies alike. Within liberal social welfare states,
populations deemed ‘those that must live,’ are those conceived “as potential or former workers,
or as vital to the reproduction of labour, [and] would be invested in through social programs”
(Willse, 2010, p. 174). Those ‘let to die,’ understood as excess and abject, were socially
contained and/or abandoned. However, through neoliberal governance, Willse notes a dramatic
shift in individual and population management: “Under neo-liberal biopolitics, the targets of
social programs need not be addressed as labour. Rather, the clients of such programmes are
labored on by social service and knowledge industries, industries that sustain rather than
challenge the neo-liberal economies that produce housing insecurity and deprivation” (Willse,
2010, p. 174). Thus under neoliberal configurations, social service economies have learned that
all bodies are a site of productive value, that can be worked and elaborated on, generating rather
than draining economies.
Within neoliberal biopolitics, technologies of self-governance remain, but become subsumed under the demand for broader efficiencies in managing homeless populations. Willse’s excellent analysis of how neoliberal biopolitics have changed operations of power within homeless service system provisions warrants elaboration, especially as it is directly relevant in contextualizing how Housing First, a program that reduces self-governing obligations on the individuals it houses, has become possible. This shift can be understood as a ‘marketization’ of homeless resources, research and knowledge industries, which overrides the imperative of disciplining the chronically homeless into responsible subjects. Within this neoliberal biopolitics of homeless management, then, “the immediate provision of housing becomes the most economically efficient means of managing this population” (Willse, 2010, p. 172). While disciplining bodies into responsible selves still works as a technological apparatus that draws on psy disciplines and other governing strategies to mediate the self, broader population dynamics calculated in relation to financial and material efficiencies and risks work to manage the chronically homeless into a body of productive value. As Willse notes, “the invention of chronic homelessness transforms housing insecurity and deprivation into productive sites of economic investment, allowing for the smooth functioning of consumer/tourist economies and the proliferation of service and knowledge industries. As economic ventures, neo-liberal social programmes do not necessarily seek an end of social problems, but become ends themselves – economic activities enabling more economic activities” (Willse, 2010, p. 175).

Thus, through the marketization of homelessness, the management of the chronically homeless becomes an economic activity, and not solely a social regulation enterprise as it was in social welfare states:

The proliferation of service agencies, the circulation of funding, the commissioning of studies and reports – all of this forms part of what scholar-activists have begun calling the ‘nonprofit
industrial complex’ (INCITE!, 2007). The non-profit industrial complex is where the post-social state meets post-industrial service and knowledge industries. Contrary to rhetoric that associates ‘the homeless’ with waste and cost, housing insecurity and deprivation prove to be the sites of economic productivity in which individuals organized as ‘chronically homeless’ become the raw material out of which studies and services are produced. (Willse, 2010, pp. 173-174)

Therefore, organizing around homelessness becomes an investment benefit, and the chronically homeless are positioned as a population to be managed and maintained, often through slow death (Berlant, 2007), rather than simply let to die. Thus within the context of Western neoliberal restructuring of social services, social economies are recalibrated and “in such a situation, illness and unproductivity may not need to be reduced or eliminated, as they would be in the social welfare state. Rather, illness and waste, and populations organized as such, become fertile sites for economic investment, as they multiply opportunities for developing and extending governance mechanisms, making economic life possible” (Willse, 2010, p. 178).

In Canada, how we move to govern the ‘chronically homeless mentally ill’ as individuals and as a population is full of contradictions. On the one hand, as Willse argues, neoliberal management strategies prioritize minimizing the costs associated with governing homeless populations. On the other hand, liberal ideals of the ‘deserving’ and ‘underserving poor’ still proliferate as they did in welfare states. That is, those that deserve the right to life are docile bodies that conform to self-disciplining strategies such as abstinence from drugs and alcohol, psychiatric medical compliance, and efforts to get back to work. Since 2006, this has been exemplified by Canada’s Conservative federal government under Stephen Harper and its ‘tough on crime’ agenda that has advanced drug policy that is dismissive of public health and harm reduction approaches to drug use. For instance, the anti-harm reduction sentiment in recent Federal drug policy is demonstrated “by the removal of harm reduction from the National Anti-Drug Strategy of 2007; federal funding cuts to harm reduction programs (Webster, 2012); the denial of a renewed exception to section 56 of the Controlled Drugs and Substances Act for Vancouver’s safe
injection site, Insite, in 2011, leading to a Supreme Court ruling that deemed the denied exemptions unconstitutional” and the recent passing of Bill C-2: Respect for Communities Act (2013), which makes it very difficult to request a Criminal Code exemption for the purpose of setting up a supervised drug consumption facility (Marshall, 2015, p. 1). This mess of contradictions – neoliberal biopolitics prioritizing population cost management, yet liberal biopolitics still invested in rewarding only those that comply to self-discipline – are operating both at once in current Federal government policy and practice.

In the specific case of Housing First models as a strategy to organize the ‘chronically homeless mentally ill,’ the neoliberal tactic of population cost-management superseded the liberal imperative to coerce unruly individuals until they submit to modeling white civil respectable modes of living. Despite the Federal government’s opposition to harm reduction models, they continue to invest and support Housing First models of housing the chronically homeless mentally ill. In my role as consumer research consultant, I heard second-hand accounts of politicians who publicly supported Housing First in speech and policy reform acts, yet behind closed doors privately questioned the relaxing of restrictions on those housed in the program model. Why has Housing First as a strategy of population management superseded the need to govern these bodies into self-governance? Perhaps these bodies are understood as too abject to invest in efforts to turn them into the ‘deserving poor’; more likely, the cost-benefit of shifting towards Housing First models outweigh the desire to prolong efforts to discipline individual bodies. As Willse notes in specific relation to the broad appeal of Housing First models

Here we have biopolitics brought to bear on individuals without the assistance of discipline. In matching the profile of the chronically homeless, subjects are in effect biopoliticized, or absorbed into a governance that regulates a population’s costs by economizing and securing its health and life chances. Concern with the apparently limited resources of municipalities – rather than with individual wellbeing – motivates this biopoliticization. The invention of chronic homelessness de-emphasizes individual
compliance with service requirements in favour of economic containment of population costs, a move that is unexpectedly benefitting an abandoned and usually despised and degraded population. The shift to population-level concerns legitimated the Housing First model not because the federal government accepted that mandatory services are paternalistic, but because it saw mandatory services as a deterrent it could no longer afford. (Willse, 2010, p. 172)

Thus the chronically homeless and their advocates welcome Housing First models in that they lessen the requirement that subjects self-govern into respectable selves. At the same time these population management models allow new economies to flourish. In essence, organizing subjects into ‘the chronically homeless body’ allows neo-liberal service industries to grow: and “the invention of chronic homelessness retrofits a social problem as an economic problem” (Willse, 2010, p. 171).

Willse shows how through neoliberal biopolitics, the management both of subjects and populations has worked to create the chronically homeless as both a subject and body for which economic investment and growth has accelerated. Through this change “the invention of chronic homelessness emerges in a context of neo-liberal economic restructuring of relationships between life, health, illness and death that moves past Foucault’s formulation of a zero-sum game in which those marked as ill or unproductive would be treated only as a negation or loss. State racism in the neo-liberal context is a process of calculation and distribution, in addition to deprivation” (Willse, 2010, p. 179). Thus, through neoliberal biopolitics, the management of the chronically homeless mentally ill allows for an economic restructuring which allows interventions to emerge “to manage costs and to transform illness and death into productive parts of post-industrial economies” and towards productive economic enterprises (Willse, 2010, p. 179). Under neoliberal austerity measures, research has come to play a central role to ensure that the economic investments made to manage ‘chronic homelessness’ are both effective and efficient.
3.4.5 Governing through Evidence-based Research

A pragmatic, multi-site, randomized controlled trial involving Housing First has yet been done in the United States, and thus the opportunity to conduct a national project of this size and scale through the At Home/Chez Soi project was met by some as just that: an opportunity to scientifically prove, through human experiment, that Housing First is better and cheaper than existing provisions. It was met by others with less enthusiasm. Many health and social housing advocates resisted both the Housing First model and the At Home/Chez Soi project. One moment illustrates this resistance: while attending the National Conference on Ending Homelessness held in Vancouver in November of 2014, I was handed a pamphlet by a group of housing activists who had decided to protest the event. The pamphlet described a march organized by the Social Housing Alliance. On the front of the page, along with an illustration of a tent city with Vancouver high rises in the background, was text that read “Build Homes Now: the market is the problem, not the solution!” followed with a slogan that read: “No more studies. Less talk more action” and “No rent supplements! No tax cuts.” On the back of the pamphlet the text read “a powerful class of managers will spend three days talking about market ‘solutions’ to a homelessness crisis that the market will never solve and is only making worse. Regimes of management, regulation, and control have been built up around low-income and Indigenous peoples’ lives, bodies, and communities. To access basic incomes and housing we are forced to submit to medical or police monitoring and control, including under the new ‘Housing First’ model” (Social Housing Alliance, N.D.).

Investing in research instead of allocating dollars towards more housing infrastructure was understood by some as a problem. The ethical dilemmas of conducting such a research project was questioned by a variety of stakeholders, including researchers (within and outside of the project), with a focus on two main questions: 1) is it ethical to randomize a control group of
‘homeless mentally ill’ people, not give them housing and services, and then study how they fare without the intervention? And 2) Funding for the project ends in April of 2013. What happens to participants when the project is over? Will those who have been housed by the project be able to keep their housing and services? What about the TAU group? If the intervention is proven successful, shouldn’t they be entitled to receive the intervention as well? These two issues became central debates within the communities that this project was entering, and much work throughout the endurance of the project was needed in order to assuage communities as well as assemble key stakeholders to ‘champion’ the project. In the early days of the project, the issue of randomization played central as a tension that continually came up to challenge the project’s undertakings; towards the end of the project, the work of trying to find housing and service sustainability for intervention group participants became more pressing.

Many community stakeholders questioned how the project received Research Ethics Board (REB) approvals. However, those familiar with REB’s were not surprised, knowing that protocols supporting randomized controlled trials that affect human lives are common practice. Indeed, the project was registered with the International Standard Randomized Control Trial Number register, and REB approvals were received by eleven healthcare and university institutions across all sites. Perhaps surprisingly, in an article published two years into the project by study researchers, the ethical issues raised by the project were not about the ethical and moral dilemmas of randomizing homeless people or questions of sustainability. Rather, it was noted that “a study of this nature raises ethical issues not faced by more traditional interventions involving, for instance, medications or psychotherapy. These include the possibility of harm to the participants, research staff and clinical personnel, due to the nature of the participants’ psychiatric problems and their living situations” (Goering et al., 2011, p. 8). Thus, the ethical
dangers presented by the project aren’t derived from the structural issues of the project itself, but
are rather located in the dangerous bodies and situations of poor and mad populations.

The demand for what has become known as evidence-based research within the business of
health and social problems has emerged through neoliberal reforms. While truth and science are
generated through many forms, and science operates to authorize some statements as truth, the
Randomized Controlled Trial has solidified as the ‘gold standard’ of scientific knowledge
production in recent years. As Ashforth notes, projects such as At Home/Chez Soi

Are not just modes of scientific investigation but are also performances which serve to
authorize a form of social discourse. They are in this sense institutions which draw upon
the authority of science to present the state of Truth and the majesty of judgement to
represent the truth to State. Every ‘problem’ in the world of modern state-makers must
have a proper name, a rational cause and a reasonable solution. The purpose of Reason in
the State (and ‘Reason of State’), then, is to allow authorities to speak properly of the
name, accurately of the cause (or of the collated causes), and responsibly of the solution
to The Problem. And in doing so, the facts are required. (Ashforth, 1990, p. 7)

The way that truth is made is always evolving. Now, the notion that evidence-based research is
needed in order to progress social policy change on how housing and mental health services (in
Canada and abroad – indeed, a study based on At Home/Chez Soi is currently taking place in
France) is a demand that is only a couple decades old. Evidence-based research is now needed to
produce evidence-based practice and medicine, and evidence-based research works as a
“motivator for funding [and] is based on the notion that mental health services, like all medical
services, should be firmly grounded in science so that consumers can be assured that the services
offered have been proven to be effective for achieving the intended outcomes” (Del vecchio &
Blyler, 2009, p. 100). Over and over again, the project as a randomized trial was justified by the
demands of government and medical professions for sound scientific research findings that prove
that Housing First works better than existing models, and that it is cost effective by way of being
less expensive than programs already in existence within the five sites. Thus the project is
justified based on the pressures and demands of outside systems need for an evidence-base before change can occur. But these relentless “calls for high stakes accountability regimes, mandates for evidence-based practice and Randomized Clinical Trials torque our social scientific and popular gaze away from the tumultuous and explicitly non-random landscape of inequality gaps . . . [and] readjust our scientific gaze, towards a discrete set of outcomes, within a structured design, where the noise, chaos, keloids and terror of life at the bottom have all been sanitized away” (Fine, 2012, p. 10). What is lost through science is the complex matrix of social inequities that render such problems possible, as RCT methodologies “normalize a scientific dissociation from the complexities of living” (Fine, 2012, p. 12).

Mykhalovskiy and Weir point to this new trend in the demand for evidence-based research, medicine, and practice as extending “its reach well beyond the domain of medicine proper. Nursing, the allied health professions, health administrators and policy makers are all fast at work rearticulating their areas of practice as evidence-based domains” (Mykhalovskiy & Weir, 2004, p. 1060). Evidence-based research and medicine, practice and policy have started to come under scrutiny within the fields of political economy. Political economy scholarship focuses on how under neoliberal cost control efforts, evidence-based regimes, “particularly in association with outcomes research, can render medicine vulnerable to administrative scrutiny, either at the hands of state authorities or private enterprise” (Mykhalovskiy & Weir, 2004, p. 1061), and humanism worries about how evidence based regimes compromise relationships through “technological oppression” (Mykhalovskiy & Weir, 2004, p. 1063).

Mykhalovskiy and Weir contribute to critiques of evidence-based medicine by showing how they are dependent on the subject as the site for the production of research. This is certainly the case within the At Home/Chez Soi project, and especially worrisome for those participants who are
placed in the control group. They argue that moral and ethical considerations “for clinical trials should not be collapsed into the frame of the medical ethics literature’s discussions of informed consent in recruitment and the treatment of research subjects during the course of trails” (Mykhalovskiy & Weir, 2004, 1066). In essence, meeting Research Ethics Board requirements is not enough. Evidence-based practices depend on bodies to produce as well as apply the evidence on, and depend on clinical trials as a precursor to applying practice:

Stating the obvious may be helpful: evidence is derived from the bodies of patients. One and only one form of evidence is privileged by evidence-based medicine, namely, the results of clinical trials. Other types of study such as cohort studies, which are far less ethically problematic than randomized clinical trials, are inferiorized and marginalized as statistically less reliable by [evidence-based medicine]. Evidence-based medicine creates a demand for clinical trials and thus the recruitment of patients into these trials. What are the effects of the evidence-based market in clinical trials on patients, on physicians and on health care? (Mykhalovskiy & Weir, 2004, p. 1066)

In particular, within this project, liberalist notions of choice in regards to participants choosing involvement in the At Home/Chez Soi project should be queried. These notions of choice are premised on the assumption that we all have equal choice. A participant choosing to be a part of a research project because they are hoping to get off the streets seems a bit of an excessive research incentive to recruit and retain research participants. While the benefit for researchers (careers are made), the Housing First model (efficacy is scientifically validated) and health care (costs are comprehended and cut) are clear, ultimately “the dangers in the constitution of patients as the site of evidence become a larger issue of health protection and citizenship rights in health care” (Mykhalovskiy & Weir, 2004, p. 1066). Within the At Home/Chez Soi project, while ‘full citizenship’ is promoted under the Housing First model, we can also see how citizenship is mitigated and negated through how it was delivered: through a randomized controlled trial.
3.5 Conclusion

I have shown in my exploration of the At Home/Chez Soi project that governing the homeless mentally ill in neoliberal times requires complex strategies and technologies that appear as neutral and ‘common-sense’ in their banality. Currently, governing social and health interventions means management through evidence-based research, evaluation, accountability, policy, business, efficacy and financial models. These apparatuses together rub up against the inclusion imperative in interesting ways and create an immediate contradiction: for peers to be ‘fully integrated’ in neoliberal health and social interventions, our knowledge needs to be understood as viable across all sectors that neoliberal governances now permeate. Yet, as I will show, our ‘expertise by experience’ remains pinned to experiences of distress that are to be used to help support and manage ‘those like us.’ Understanding the complexity of the work that the At Home/Chez Soi project generates is crucial in understanding what role peers play, and don’t play, in this assemblage: as I will show, peer work remains useful when we remain tied to working with those like us, but when we attempt to ‘study up’ and intervene and integrate within other professional realms, our knowledge because useless, minor, or a problem that requires management. In the following chapter, I explore the ways in which inclusion has emerged as a new technology of rule in mental health governance.
Chapter 3
Troubling Inclusion: The Participatory Turn in Mental Health

4.1 Introduction
This chapter shows how participation and the ‘inclusion imperative’ discussed in the last chapter have now become a new tactic of governance in mental health. In Part One of this chapter, I explore how a number of diverse events together contributed to making peer participation possible. First, I explore the ‘crisis in representation,’ a largely postcolonial scholarly intervention brought forth to challenge the imperial basis of knowledge production through the inclusion of the voices of the dispossessed and marginalized. This impulse generated the ‘participatory turn,’ an attempt to ensure a more ethical practice through representational involvement in a variety of community interventions. I draw on an outstanding critique of participation developed by Bill Cooke and Uma Kothari (2001a) in their edited book *Participation: The New Tyranny* to consider the history of participatory discourses in other fields, and how they influenced the participatory turn in mental health. I follow by considering key factors that helped foster participation as a practice in mental health. I show how disability social movement activism and consumer/survivor advocacy helped establish early participatory practices in mental health in Ontario in the 1980s. In the same decade, the rise of the recovery model approach to mental health emerged, a model which positioned people with experiences of distress/contact with the mental health systems as ‘experts by experience.’ In this chapter I trace the evolution of the concept of experts by experience, showing how the participatory turn worked to fracture collective movements and to feature instead individual action. Participatory involvement in mental health fields has since come to be understood as a best practice.
Part Two of this chapter specifically explores the possibilities, conditions, and limits of peer participation within mental health fields. I explore two consequences of the individualizing move underpinning participation. First, the literature on peer participation understands power to be exchanged through local and interpersonal exchange, and has so far largely failed to address how peer participation works to sustain larger systemic and structural systems of power in mental health assemblages. A review of the literature on peer participation shows that much of it is focused on ‘how to do participation well,’ similar to the internal critiques found in participatory development literatures. Secondly, I show how new regimes of positivistic knowledge production have emerged to study the effects of participation on both those who work as peers as well as those who receive interventions from them. In this way, peer participation provokes the need for new forms of knowledge production that work within evidence-based research and practice models that solidify the need for Randomized Controlled Trials, the need to quantify problems and effects, and ultimately, the need to govern. In this way, peer participation is a new field of power that has absorbed within the logics of both dominant and recovery-oriented interventions, adding to regimes of truth that corroborate mental health governances. Thus, peer work as a participatory practice illustrates the process by which we come to be authorized to govern ourselves and others through experiential claims.

4.2 Part One: Responding to Resistance

A half-century ago, postcolonial scholars began emphasizing how social science research was intimately tied to Western colonial and neocolonial projects of empire and nation-building (Asad, 1973; Ortner, 1984; Said, 1989; Trinh, 1989). Consequently, the discipline of anthropology, foremost among others, came under heavy fire. As Marcus and Fischer noted, anthropology was criticized for its “ineffectiveness in dealing with issues of historical context
and political economy, relevant not only to its subjects, but also to its own research process, developed during the 1960’s specifically as a questioning of the discipline’s relationship to colonialism, and more recently, to neocolonialism” (1986, p. 34). Further, the field presented itself as ahistorical and apolitical objective science, which obscured how anthropological studies are motivated and aligned with projects that strengthen and sustain imperialisms.

Along with this postcolonial deconstruction of anthropology’s legacy arose issues of how subjects under scrutiny come to be represented within social science studies. Works like Edward Said’s *Orientalism* (1978) located how anthropology and the broader social sciences produced knowledge that authorized Western authors as active, and those under study as passive. Further, that knowledge production is always embedded in neo/colonial relations, and that social science projects of studying difference and marking that difference as primitive and dying in the face of Western progress works to support and sustain the subjugation of difference for very real material gain. And ultimately, that Western knowledge production was itself an exercise of power, by obscuring from the reader recognition that the subjects under study “might view things with equal validity, quite differently from the writer” (Marcus & Fischer, 1986, p. 1). Suddenly, social science became troubled in ways that risked delegitimizing anthropology’s authority as a discipline.

Together with the crisis in representation, other developments, such as community-based participatory research principles and best practices, the mental health recovery movement, consumer/survivor/ex-patient and mad activism and advocacy, and the paraprofessionalization of peer work, have all merged to allow for our present moment, whereby those of us with lived experience of distress and/or the mental health system are working both within and outside of mental health fields of power to contribute, disrupt, and complicate how and what knowledge is
produced about us. Aligned with Postcolonial, Feminist, Queer, Critical Anti-Racist, Disability, and other critical theoretical and social movements, we have used our experiential knowledge and subject positions to sanction our knowledge and inclusion. Yet, unlike most fields, those of us who use our experiences of madness/distress to position ourselves as ‘experts by experience’ have yet to openly engage with the hard questions on the possibilities, limits, and conditions of relying on experiential knowledge to authorize our standing (Alcoff, 1991; Valverde, 2004).

While the crisis in representation was a scholarly intervention which shifted the way in which experiential knowledge could be understood as knowledge proper, and created contestations on who could partake in the production of knowledge, the effects of this crisis have permeated how knowledge can be made, especially in community settings. One of the fields that the crisis in representation targeted was international development. Recognizing the imperialist functions and the shortcomings of top-down development models often imposed by Western planning and research experts working outside of the communities in which they are intervening, participatory development has been taken up as an alternative model in response to the problem with traditional international development models. The broad motivation behind participatory practices within international development are to “make ‘people’ central to development by encouraging beneficiary involvement in interventions that affect them and over which they previously had limited control and influence, in response to the ‘older misguided orthodoxy of development’” (Henkel & Stirrat, 2001, p. 169). Similar to the motivations often cited for the involvement of peers in mental health interventions, which often construct participation as increasing individual empowerment and efficacy, offering a minor redistribution of resources, as well as making structural contributions to the relevance and implementation of recovery-oriented research and service system, participatory development offers “recognition and support for greater involvement of ‘local’ people’s perspectives, knowledge, priorities and skills presented
an alternative to donor-driven and outsider-led development and was rapidly and widely adopted by individuals and organizations. Participatory approaches to development, then, are justified in terms of sustainability, relevance and empowerment” (Cooke and Kothari, 2001b, p. 5).

In Cooke and Kothari’s (2001a) edited volume Participation: The New Tyranny? contributors explore the complexity of participatory development as it has emerged, and address both the ‘internal’ and ‘external’ critiques of participatory development models. They note that these two forms of critique hold different sites of analysis and goals: the first, referred to as internal critiques, relies on an effort in locating the individual and technical limitations of the approaches to inclusion made possible within participatory practices, and finding solutions on how to do participatory models better by, for example, improving the methodological tools used to ensure ‘meaningful’ inclusion. Internal critiques of participatory development hold that “participation is intrinsically a ‘good thing’ (especially for the participants); that a focus on ‘getting the techniques right’ is a principle way of ensuring the success of such approaches; and that considerations of power and politics on the whole should be avoided as divisive and obstructive” (Cleaver, 2001, p. 36). Thus, by drawing on case studies, lessons learned, new models of approach, and interpersonal behavioural modification, these tactics are used to strengthen participatory involvement into a more robust, meaningful inclusion within participatory development (see Florisbelo & Guijt, 2004). Processes such as reflexivity, self-critique of the practitioner, identifying problems within the methodology and offering solutions are encouraged, but do not represent a critique of participatory development itself, but rather how to do it better.

Thus, the problems of participatory development are understood as requiring identification internally through the process itself, and “in this way, the methodological and practical problems of the approach are supposed to be recognized, highlighted and subsequently addressed” (Cooke
and Kothari, 2001b, p. 6). Thus, through internal critiques, techniques of participation – that is, how to manage participation best – are what become the focus of redress. Ultimately, “such ‘paradigm shifts’ leave existing power relations undisturbed and thus, whatever kind of post-something they are, they are not post-capitalist” (Taylor, 2001, p. 131). Improving on community-based methodologies in order to strengthen the effectiveness of participatory development focuses on individual, interpersonal, and cultural relations.

Alternately, external critiques of participatory development challenge the conceptual limitations of participation, and identifying ways in which participatory methods not only fail to challenge the imperialist, socio-political and economic investments of transnational developments, but also work to sustain and support ongoing systemic exploitations. Through international development, participation becomes a way of inviting racial others to manage themselves and those ‘like them,’ showing that power is diffuse and negotiated in complex and competing ways. Cooke and Kothari note that those who have contributed to re-visioning participatory methods in order to improve meaningful participation have obscured the fundamental problem within participatory discourses, and ask us to reflect on how “internal critiques have served to legitimize the participatory project rather than present it with a real challenge” (2001b, p. 7). Taylor notes that “participation has never been radical,” nor intended to transform prevailing ruling relations, but rather participatory developments have largely been fostered and sponsored by organizations in order to maintain hegemonic investments (Taylor, 2001, p. 136). Instead of questioning how participation can be done better, this approach, which my dissertation follows, asks how participation works to obscure and maintain the larger problems of ‘improvement’ interventions. What are the politics of participation producing? What are they effacing? And what are the limits of participatory models? In essence, what do participatory discourses do in order to limit the need to undo larger structural ruling relations?
External critiques of participation reject simplistic notions of power as solving the problem of oppression through power-sharing. Rather, they refocus on the problems of what organizations produce and sustain (Taylor, 2001, pp. 129-130), partially because of their ability to harness participation. Participation should be understood as “messy and difficult, approximate and unpredictable in outcome” (Cleaver, 2001, p. 37), and scholarship exploring how participants’ subjects and subjectivities are constituted through participatory projects is needed: how power circulates through individual, intra-organizational, and social structure negotiations, as well as where spaces of subversion exist when performing participation (Kothari, 2001). In order to “raise the consciousness of the deception of participatory development,” (Taylor, 2001, p. 138), scholarship and activist work needs to aim at deconstructing the ‘participatory turn,’ and reframing focus on what it sustains, such as how participatory projects collude with ongoing colonization (Mohan, 2001). Exploring the conditions and limits of what participation produces, while keeping an eye on what participation maintains offers a more nuanced understanding of how power absorbs, entrenches and reconfigures through participatory practices without the substantive restructuring of systems of domination. These are all areas of inquiry that my research relies on to map the case study of peer workers with the At Home/Chez Soi project.

4.2.1 From Patients to Participators: The Effects of Social Movements
How has participation in mental health research and service systems materialized through strategies of resistance? While the participatory turn in mental health has certainly emerged in different ways than in international development, the crisis in representation and social and protest movements of the 1960’s and 1970’s forged a change in the ways in which both mental health could conduct its business. In this section I explore how the disability rights movement more generally, and specifically the consumer/survivor/ex-patient (c/s/x) movement, by
harnessing representational debates, forced systems of power to confront their paternalistic exclusion of those with experiential knowledge of psychiatric disabilities and confront issues of rights, recourse and participation within systems that involved them. Working concurrently with the transitional shift in the 1980s towards a ‘consumerist’ business model restructuring of how health care was provided, these technologies of resistance changed the ways in which people receiving mental health services engaged: from passive patients to active clients and ‘consumers’ with contributions to make in how ‘care’ is directed.

The disability rights movement emerged in conjunction with the gay and lesbian, civil rights, Black, women’s and environmental movements of the 1970s. Issues central to the disability rights movement include issues of citizenship, human rights, state welfare and health supports, access and accommodation, employment, discrimination, and also converged with others identity politics of race, class, sexuality, nationality, citizenship, and so on. Influenced by this movement, the field of Disability Studies later emerged. A popular mantra used by the disability rights movement, “Nothing about us without us,” urged for social, political and policy changes that allowed for disabled people to “speak for themselves” instead of other groups speaking on their behalf. Here the primary concern has been with empowerment, the redistribution of power and people gaining more say and control over their lives” (Croft & Beresford, 1996, p. 186). For more on the disability rights movement, see Barnartt & Scott (2001); Darling (2013); Winter (2003).

Those who had experienced the psychiatric system also began to organize in the 1960s and 1970s, as “scholars, activists and people who would later self-identify as survivors of the mental health system began to mobilize against the advancing powers of psychiatry along a number of divergent (and often mutually colliding) fronts” (Menzies, LeFrançois & Reaume, 2013, p. 4).
The shift from carceral containment towards deinstitutionalization and community care allowed for those impacted by psychiatry to organize outside of institutional settings and react to the new ‘psychiatric society’: which included the strengthening of biomedical therapeutics, the solidification and spread of DSM diagnostics, and first-generation antipsychotic medications. These activists and advocates focused on “championing human rights for psychiatrized citizens, and in opposition to the burgeoning therapeutic state and the medicalization of everyday life; from arbitrary, exclusionary, racist, homophobic, gender-based diagnostic codes and interventions; to involuntary mental confinement and enforced ‘treatment’; to electroshock, Big Pharma, and the profusion of chemical straightjackets branded as therapy: and, increasingly, to systemic deinstitutionalization and the wholesale urban ghettoizing of ex-patients under the transparent deceit of ‘downsizing’ and ‘reintegration’” (Menzies, LeFrançois & Reaume, 2013, p. 5). Those resisting and ‘talking back’ to psychiatry initially identified as part of the mental patients liberation movement, and then the consumer/survivor/ex-patient (c/s/x) movement as well as the more recent Mad movement in North America, whereas in the United Kingdom the language of psychiatric survivor or service user movements is more commonly used.

4.2.2 Early Consumer/Survivor Participation in Ontario

An early example of how the activism and advocacy of the c/s/x movement in turn led to the shift from patients to participants can be found in the 1980s and the assemblage work done within the Canadian Mental Health Association (CMHA). In the book Forbidden Narratives: Critical Autobiography as Social Science, Kathryn Church documents the shift in individual and organizational culture as c/s/x community members came to be included in consultations. External social movement pressures and critiques were beginning to impact organizational procedure, and Church’s early 1980s work for CMHA produced, among other things, a 1984
report titled "A Framework for Support for People with Severe Mental Disabilities" that "advanced the notion that consumers of mental health services should be active participants in planning and operating the mental health system" (Church, 1995, p. 18). Church notes however, that at the time of writing, "there were no consumers of service on my volunteer committee, none on national staff, and none sitting as members of the national board," and thus the report was all conceptual (Church, 1995, p. 18). The opportunity to put theory into practice came a year later under the Framework Project, through which a 1985 conference was held that brought those experiencing the mental health system together "whose attitudes to being at a CMHA-sponsored event ranged from delight to hostility and whose politics ranged from conservative to radical" (Church, 1995, p. 19). Some in attendance became involved in the project and "structures were invented to give them formal status" (Church, 1995, p. 19). At that same time, David Reville, a member of the Ontario provincial parliament and open about his experiences as a psychiatric patient, was appointed to CMHA’s Mental Health Services Committee – the first psychiatric survivor to occupy a seat within CMHA. These early opening moments of participation within CMHA were quickly met with contestation and closure: room for development disappeared and close governance kicked in. The Framework Project became "monitored more closely to see that its activities did not jeopardize other organizational activities and sources of funding" (Church, 1995, p. 20). Further, as more "volunteers and survivors appeared on the scene, other employees felt deeply threatened" (Church, 1995, p. 20). The opportunities that consumer participation presented within the mental health organization at the same time became risk and liability. With change came management; with management, moments of foreclosure.

But other openings in Ontario provided venues for consumers, survivors, and ex-patients to participate. When the Liberals came to power in the province in 1985, their health strategy included policy reform on mental health, and they commissioned the Graham Report, which was
released in 1988. As Costa notes, “during consultations, Robert Graham, the report’s lead author, heard from both professionals and c/s/x groups; this was a first in having patients participate in policy discussion. One of the recommendations of the Graham Report stated that ‘greater efforts should be made to solicit views and opinions of consumers’” (Costa, 2013, p. 197). These early consultations with those affected by mental health systems changed the ways that the business of mental health could proceed, and started to make ‘client participation’ one of the new procedural requirements for mental health decision-making.

Church and Reville document the politics of early participation in the article “Do the Right Thing* Right,” following a 1990 Ontario Ministry of Health public consultation on community mental health services legislation which was fuelled by the Graham report. The document explores the particularities of engaging consumer/survivors as participants in consultations, and the authors worked both as actors who encouraged consumer/survivors to attend the hearings, then documenting how the process of consumer/survivor participation was handled and experienced. The report worked to “contribute to the debate on ‘consumer participation’ which is currently a significant policy issue within the health and social services fields” (Church & Reville, 1990, p. 77). What this document helps to mark is that in Ontario at the time, participation was still rare and contested terrain. Yet, within a few years it was to become a given as a ‘best practice.’ It also shows how now, over two decades later, consumer/survivors participating in the mental health and social services sectors that affect them are still running into similar practice issues and constraints.

This early consumer/survivor consultation process, as experienced by consumer/survivors, was ineffective on a number of fronts. As Church and Reville note, the timeframe for the Ontario consultation was rushed, limiting the ability or willingness for consumer/survivors to engage: for
example, “one self-help group received a letter in mid-March which indicated that their group had until the 28th of the month to reserve a five to ten minute slot for an oral presentation. In their initial discussion of the letter they decided that going all the way to another city for five minutes was not a priority for their time” (Church & Reville, 1990, p. 79). Further, the consultation process was urban-centred, and consultations were arranged in a geographical manner that did not match rural/northern Ontario realities, which further marginalized representational possibilities for rural/Northern representation. Other spatial matters included consultation venues: most were held in hotels. While such spaces may be friendly to those who occupy privilege, those marginalized can experience them as hostile environments. Consumer/survivors often “smoke heavily; medications make people thirsty and restless. A comfortable environment under these circumstances is one in which some conscious attention has been paid to practical arrangements for food, drink, and space” (Church & Reville, 1990, p. 80).

Outreach to consumer/survivors was solicited through organizations. This acts to harness representation of those who are connected through services, and doesn’t recruit “independent (usually service-alienated) groups or individuals” (Church & Reville, 1990, p. 79). Consultations that reach only consumer/survivors who are affiliated with mental health/social service organizations excludes those who “remain outside of organizations like the CMHA by deliberate political choice and/or because of structural barriers to their presence” and erases the often “angry voice” of those who are refuted, refuse, or resist organizational services (Church & Reville, 1990, p. 79). Financial planning ahead of time to ensure that consumer/survivors were able to participate was not intentional: there was “no clear written guidelines for facilitating consumer participation through subsidization prior to organizing” (Church & Reville, 1990, p. 79). Thus, early on, process issues of who, how, how much, when and where were identified.
The terms of engagement were also identified as troubled in regards to the content of the document under review. Some did not receive it; others without adequate time to review it. The discussion paper was characterized as both “complex and vague,” the focus “held no particular relevance to life as they experience it,” and the language of legislative reform was alienating, causing some to assume that these “issues were beyond their comprehension” (Church & Reville, 1990, p. 79). Constructing documents and then seeking quick community consultation prior to implementation allows for only reaction to a pre-set agenda, one that ‘professionals’ may be more comfortable and used to. Consumer/survivors made attempts to redefine the topics covered, often through individual and collective experiences of “hate, prejudice and poverty, about self-help, capacity and power, about loss, suffering and struggle,” airing discourse often conceptualized as individual and personal into public professional forms. It requires a reordering of set agendas, which can feel like a threatening disorder to those who are used to “the rules for speech and behavior which characterize professional/agency meetings” (Church & Reville, 1990, p. 80).

Stemming for this work at the time, recommendations were then presented to the Graham legislative subcommittee, which asked that future consumer/survivor consultations include paying attention to space, place, and representation; consumer/survivors need to be members of the planning authority, not just as consultants to pre-formed documents; professionals need “consumer/survivor sensitization and training” to learn terms of engagement outside of professional/patient relations (Church & Reville, 1990, p. 81). These basic ‘how-to’ tenets on consumer/survivor participation, ‘discovered’ almost a quarter century ago, continue to be forgotten by mental health and social service systems as consumer/survivor consultations have become required procedure. And again, rediscovered as new initiatives are born, as professionals are reminded of them by consumer/survivors and their organizations, as academics rediscover
them through community and research engagements and write them up, a constant process of re-writing a history of knowledge that never seems to hold as knowledge that has already been produced, revised, reformed, and reiterated.

Becoming an ‘insider’ by participating within procedures and systems that affected us slowly became common in Ontario, while at the same time those who have experienced the mental health system worked to develop funded c/s/x-only groups concerning self help and support (e.g. Toronto’s Sound Times Support Services), advocacy (e.g. Toronto’s The Empowerment Council), and consumer/survivor employment ventures (e.g. Toronto’s A-Way Express Couriers and Green Thumb Enterprises), as well as patient councils, coalitions and networks (for more on the history of consumer/survivor initiatives, see: Consumer/Survivor Business Council of Ontario, 1995; Janzen, Nelson, Trainor & Ochocka, 2006; Nelson et al., 2007). The c/s/x movement continued work at grassroots levels, usually unfunded. Tensions within the movement continue to this day surrounding the politics of participation: critics of those who are willing to work as ‘insiders’ within mental health systems often argue that co-optation and control are the only inevitable results. Conversely, consumer/survivor-run organizations are often also critiqued, accused of ‘ghettoizing’ those with disabilities rather than offering integration and normalization within larger social-structure systems.

4.2.3 The Roots and Rise of Recovery

Another shift that began in the 1980s and that has worked to promote consumer/survivor involvement in mental and social service systems is the emergence of the recovery movement or vision, which is now commonly referred to as the recovery model. The history of recovery in mental health as it now stands is a “mélange of beliefs and values that emerged from a number of disparate intellectuals and social movements, including antipsychiatry of the late 1960s and early
1970s, the psychiatric survivor movement of the 1970s, and the broad-based consumer rights movement of the past half-century” (Braslow, 2013, p. 783). Stemming very much from the activism and advocacy of the c/s/x movement, the recovery movement as defined by Patricia Deegan, a survivor and understood as one of the founders of this framework, counters the notion that mental illness is a chronic lifelong disease, and that once diagnosed one can ‘never recover.’ Rather, early recovery leaders such as Deegan and William Anthony argue that recovery is a “deeply personal, unique process” (Anthony, 1993) made possible through “hope, willingness and responsible action” (Deegan, 1998, p. 14) by the individual in distress, and in conjunction with recovery-oriented supports, one can manage or recover from their distress. Thus, drawing on technologies of subjectivity and self, recovery offers advanced liberal techniques of governing the self.

The recovery model began to emerge in the 1980s during a time of criticism and crisis, where large scale deinstitutionalization had not been matched with funding for community support. This meant that managing the mentally ill needed to be done in new ways, “for the failures of one mode of governing are opportunities for the formulation of another” (Miller & Rose, 2008, p. 17). While the roots of recovery may have originated in a radical recalcitrance of traditional approaches to madness as biological mental illness to be cured by the psy disciplines, it has slowly been acknowledged and absorbed by dominate mental health systems as a newer and less costly way of encouraging those to self-govern. Thus, in the last several decades, discursive fields and regimes of practices have been circulating in order to establish regimes of truth about what recovery means. Early formulations of what recovery means and how it can be supported have been taken up in a multitude of ways since its first renderings. Efforts to define and create boundaries around what recovery means have been constructed and debated: The New Freedom Commission’s definition posits recovery as “the process in which people are able to live, work,
learn, and participate fully in their communities. For some, individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms” (2003, p.5). Scholarship and studies continue to work to define and establish consensus as to what recovery is, as well as what that means for both those who receive as well as those who provide services (Law & Morrison, 2014). Recovery as an alternative model of care began through self-help and advocacy organizations, and slowly yet surely moved to develop a variety of philosophical, practical, clinical, and social practiced-based models that together have moved forward to challenge, contend and compete with clinical and carceral models of care.

Grant refers to this emergent model of care as fundamentally challenging the dominant model of mental health provisions: traditionally characterized as clinical, bureaucratic and impersonal, the dominant model is “constructed and supported by a pathological understanding of that which we label as mental illness” (2010, p. 60). In contrast, the emerging model of care, heavily influenced by the recovery model and incorporating many of its original tenets, allows for a psychosocial approach to treatment, taking into account social determinants of health, and the locus of care expands from just biomedical intervention towards professional and client collaboration in self-directed services that are focused on overall wellbeing (Firth, 2010). The recovery model approach to mental health and illness, and the ways in which it has been mainstreamed into pre-existing services, as well as developed new intervention models, has reworked mental health policy and practice in Canada and beyond. The recovery model thus rejects the mentally ill as unable, and places them as central and responsible for their care and wellbeing, fitting well with neoliberal disciplinary techniques.
Diverse in its appeal, with the promise of cost-savings to boot, “recovery was adopted by the administration of former U.S. president George Bush as part of its New Freedom Commission on Mental Health. Similarly, governments in Scotland, New Zealand and across Europe have made recovery the core of all their mental health policy and practice” (Poole, 2011, p. 10). The Mental Health Commission of Canada positions itself, not without contestation, as recovery-oriented. One of its most important mandates, to develop a national mental health strategy for Canada, which was undertaken in two distinct phases, positions recovery as central to re-visioning mental health care in Canada. The first report, “Towards Recovery and Well-Being: A Framework for a Mental Health Strategy in Canada” (2009) locates the MHCC itself as invested in recovery, and encourages the nation to shift in thought and practice towards recovery models of service provision. This report situates recovery as an individual journey which builds on self, family, cultural, and community supports, but is careful to note that “recovery does not necessarily mean ‘cure,’ although it does acknowledge that ‘cure’ is possible for many people. Recovery principles – including hope, empowerment, self-determination and responsibility” are to be harnessed by individuals, “but must also be adapted to the realities of the different stages of life” (MHCC, 2009, p. 122). The second and final phase in the development of a national strategy was accomplished in 2012 with the release of “Changing Directions, Changing Minds: The Mental Health Strategy for Canada.” While still rooted in recovery, the document promotes a mix of biological, psychosocial, and recovery-oriented services, and while still upholding a focus on fostering “recovery and well-being for people of all ages living with mental health problems and illnesses” (MHCC, 2012, p. 11), recovery discourse reads more muted when compared to the first framework report.

Part of this can be attributed to a leaked draft version of the “Changing Directions, Changing Lives” report six months prior to its release, which caused turmoil within the organization. The
draft was met with mixed reviews, and some high-profile press pushback from various sectors complained that the MHCC was too recovery-oriented and not attuned to the realities of the severe mentally ill (Inman, 2011). Morrow notes how “media reactions in 2011 to the MHCC draft strategy suggest that at least some members of the general population and health opinion-makers are hostile to any kind of rebalancing of the mental health system towards the aims of mental health recovery and promotion” (Morrow, 2013, p. 323). It was a reminder that organizations such as the MHCC have to be cautious how they embrace recovery: careful to emphasize that recovery doesn’t mean cure, honouring individual ‘realities,’ and carefully considering the language and practice promoted in order to not alienate the competing perspectives, stakeholders and resources that hold powers within the mental health fields. Speaking of recovery means not disaffecting consumers who are unable to manage or recover themselves: those for which “living with’ this situation through ‘coping’ and ‘acceptance’ is a more realistic goal than ‘recovery from’ in the sense of effecting a cure” (MHRSWG, 2009, p. 19). Perhaps more importantly, recovery language needs to also not alienate governments, psychiatrists, lawyers, and brain scientists who hold continued investments in the dominant model approach to mental illness. Yet at the same time, the approaches must speak to the people, professionals and systems that are invested in recovery both as a philosophy and a program model of reforming mental health systems. In the current moment, regimes of truth must work to incorporate both dominant biomedical and recovery oriented approaches, while estranging neither.

Recovery has been taken up and taken away in a number of different ways, and often by oppositional groups. Taken up by activists and advocates attracted to recovery’s challenge to the biomedical model, which is understood as “stamping out hope by implying that biology is destiny and emphasizing an external locus of control … Some consumer advocates view the
physician as a powerful and oppressive figure who ‘at best is acting out of misguided beneficial’ and at worst fosters ‘helplessness and chronicity’” (Frese, Stanely, Kress, & Vogel-Scibilia, 2001, pp. 1463-1464). Thus recovery appeals “to those concerned with issues of power and oppression” as it offers a model that rejects defining oneself through diagnosis, highlights value in lived experience and self-help, and challenges professional authority (Poole, 2011, p. 10). Taken up by clinicians, strains of the recovery model (often referred to as clinical recovery) have been incorporated as ‘add-ons’ to dominant model approaches to mental illness. An example of clinical recovery would be how, within an Assertive Community Treatment team, peer support workers are hired “to promote client-centred practices by the deployment of a peer specialist” whose role includes “referring clients to consumer self-help programs and advocacy organizations that promote recovery” (Ministry of Health & Long-term Care, 2004, p. 27). Thus, within ACT teams, peer support works to offer recovery-oriented help to complement their medical (nurses), psychiatric (psychiatrists), and psychosocial (social workers) teammates. While ACT teams are often cited as recovery-oriented, at their core, they are clinical community interventions (Ministry of Health & Long-term Care, 2004, p. 14).

The recovery model, which emphasizes attending to social determinants of health such as housing, reforming disability benefits and employment supports, and alternative health care, offers confirmation that social (and not just biomedical) mental health investments need to be made in order to support recovery. In an environment where different fields of power are competing for always-limited resources (for example, neuroscientists and social workers and c/s/x organizations are often all competing within the same funding streams), those working within the dominant model of clinical settings have worked to adapt clinical recovery in order to secure and expand their program funding. Those working in psychosocial models of care have adapted and promoted their programming as recovery-oriented, also as a way to secure and
expand their funding. And consumer/survivor-run organizations are able to use the recovery model’s emphasis on self-initiation and independence, peer-on-peer support, community building and self-efficacy to support their initiatives. In this way, as the recovery model has been adapted, it has become a tool to help define and defend different and often competing/conflicting paradigms that have been willing to shift in language and some in practice in order to mark their organizations and programming as recovery-oriented and informed.

In *Behind the Rhetoric: Mental Health Recovery in Ontario* (2011), Poole suggests two different philosophic approaches to recovery: On the one hand, some have adopted recovery as a discourse that signifies ‘recovery in,’ while others used recovery to connote ‘recovery from.’ The former is rooted in social movement activisms and, “informed by self-help, it does not presume a return to ‘normal functioning’ nor any kind of ‘remission’ of symptoms. What ‘recovery in’ does presume is that recovery must be grounded in a focus on survivor rights, peer support and recovering from the oppressive effects of being a mental patient” (Poole, 2011, p. 15). The latter positions ‘recovery from’ mental illness as viable scientific truth: it is “a clear and measurable concept steeped in rigorous longitudinal research studies. Contrary to previous medical arguments, these studies claim 25 to 50 percent of people with mental health issues will, at some point, resume normal activities” (Poole, 2011, p. 15). ‘Recovery in’ sits within disability-positive and social model frameworks of embracing difference and troubling normalcy as a regime of ruling. ‘Recovery from’ emphasizes rehabilitation and potential cure, assumes a desired return to normalcy, but still recognizes social determinants of health as contributing to mental health outcomes.

What does providing recovery-oriented care mean? A plethora of ‘models’ have developed that combine specific tools and philosophies of change in order to produce recovery: “The Canadian-
based team of Ochaka, Nelson and Janzen (2005) developed one useful model. But there is also the Ohio Model, the Maine Model, the Pace Model, the Tidal Model and a conceptual model developed by Jacobson and Greenley (2001)” (Poole, 2011, p. 15). In 2004, a U.S. national expert panel suggested that mechanisms necessary for recovery-based practice must hold ten fundamental recovery components, promoting qualities of “self-direction, individualized and person-centred, empowerment, holistic, nonlinear, strengths based, peer support, respect, responsibility and hope” (Braslow, 2013, p. 784). Based on these tenets, recovery models in practice include self and mutual care, support programs and provisions such as yoga classes and other exercise regimes, incorporating alternative and non-Western medical and cultural practices into treatment plans, peer support embedded in clinical and community care, mental health organizations advocating for social determinants of health reform, and training, educational and employment programs. In essence, building on the age-old needs mantra of ‘a friend, a home, and a job.’ Training, such as Copeland’s Wellness Recovery Action Plan (WRAP) has now been implemented across North America to support both those in recovery and those who want to become peer support workers (Copeland, 2006). Many have shared their own tools for recovery, which are often a combination of peer support, wellness-based, and clinical integrations (Pool, 2011, p. 10).

As recovery models emerged, in the age of evidence-based research, dominant model, emerging model, and peer-based research has all worked to ‘prove’ that recovery models work. As noted by the Mental Health ‘Recovery; Study Working Group (MHRSWG) in their report “Mental Health Recovery: Users and Refusers” which explores what psychiatric survivors in Toronto think about mental health recovery

A surge of research on ‘recovery’ has accompanied this new vision for mental health. Harding (1986) tracked the outcomes of discharged patients over a 25 year period,
providing the first ‘proof’ that recovery might indeed be possible. Psychosocial rehabilitation researcher William Anthony outlined how to put it into practice (e.g. 1993). A cluster of consumer-writer-researchers including Pat Deegan have written extensively on its ‘lived experience.’ Nora Jacobson (2004) has explored how it became policy in Wisconsin during the late 1990’s, and Repper and Perkins (2003) have made clear that it is the only ‘model of practice’ to speak to issues of social inclusion in mental health. (MHRSWG, 2009, p. 6)

Evidence-based research is used to prove that recovery models of support offer positive health and welfare outcomes. And proof leads to policy and practice change: “With this growing store of proof, many U.S. state governments have moved towards recovery as the guiding creed for local mental health policy, planning and practice” (Poole, 2011, p. 16). Under the name of the recovery model, and now backed up by evidence, change has ranged from speaking differently while working under the same paradigms to more funding for recovery-oriented supports and strategies, self-help groups, community supports, employment, and participation projects (Poole, 2011, p. 16).

4.2.4 Clinical Recovery and the At Home/Chez Soi Project

The At Home/Chez Soi project is a recovery-oriented research project. It was established to implement Housing First programs, which offer recovery-informed support. Both research and services are based in the premise of recovery. At Home/Chez Soi is also a registered clinical trial, where the intervention is understood and funded as a medical one, and set up as an RCT as a new medication clinical trial would be. It thus conjoins biomedical and recovery discourses together under one operational field. It is noteworthy that while the project offers both housing and mental health supports to the homeless mentally ill, with an emphasis on housing as the first component necessary in order to stabilize an individual, it is still set up and funded as a medical, rather than a social housing intervention. This is an example of how social justice issues such as housing in Canada have come to be framed as health problems, as “social problems are refracted
through a public health prism” (Meyer & Schwartz as cited in Morrow, 2013, p. 329). Morrow
points to how currently “housing is garnered not by activists resisting poverty, but by experts
who demonstrate that it is people with mental illness and addictions who populate our streets and
must be housed because of their severe health problems” (Morrow, 2013, p. 329). Many scholars
continue to counteract metanarratives of mental illness as the main cause of increases in
homelessness, dismissing such approaches as simplistic and used to “explain away the
phenomenon of homelessness” (Passaro, 1996, p.28).

The At Home/Chez Soi project is both clinical and recovery-oriented: a merging of two formerly
oppositional paradigms of practice. It is at once a part of the dominant and the emerging
structure of service delivery. A concrete example of this merger into clinical recovery
approaches is provided by even a cursory overview of the extensive quantitative research
instruments that were used nationally across the twenty-one month data collection period of the
project. The very first instrument administered to participants interested in partaking in the study
was the eligibility screening instrument. The MINI International Neuropsychiatry instrument was
used to assess whether the potential participant had mental illness, which was a criterion to
qualify as a participant in the study (Sheehan & Lecrubier, 2010). In essence, this MINI
assessment works to produce the participant as mentally ill. Responding ‘yes’ in this tool to
questions on whether the potential participant has been depressed, had delusional thoughts, or
been suicidal in the last two weeks gives researchers an initial assessment of mental illness. An
affirmative response also qualifies the potential participant to move on to more questions that
determine whether they are homeless. If a person is both mentally ill and homeless as assessed
by these instruments, they can become a participant. These clinical instruments produce
participants as ‘the homeless mentally ill’ through standardized clinical assessments, a very
dominant model way of treating individuals.
Conjointly in the instrument tools, but at a later time point in the study, the Recovery Assessment Scale was used to collect data on participants’ well-being, as “recovery is seen as an increasingly important process leading to better outcomes for those with mental health problems and illnesses, and is a cornerstone of the Mental Health Commission’s strategies for mental health system change” (At Home/Chez Soi, 2010, p. 11). This instrument was used to measure self-reported data on questions about a participant’s goals, plans, self-esteem, hope, and social support networks. While still encased in the language of ‘mental illness,’ this recovery scale focuses on affective questions of the self: recovery within this scale comes to mean positive psychology. This small example of how recovery models have been blended into larger clinical procedures help to explain the confusion over just what recovery means. It has become an adaptable discourse, spread across competing/conflicting paradigms, at once a radical transformation, a co-optable tool, and an amenable add-on to existing biopowers. Many continue to ask “recovery from what, recovery to what and whose recovery is it anyways?” (Turner-Crowson & Wallcraft as cited in Poole, 2011, p. 17).

At one point, about half-way through the At Home/Chez Soi research project, during one of our thrice annual in-person National Research Team meetings, one of the researchers on the project scuffled over the repeated use of the language of ‘recovery’ during our meeting and asked, “What are we actually meaning when we are saying ‘recovery?’ We aren’t meaning it in the way of physical illness, like cancer or something, inferring that there is a an absolute cure or, …?” Trailing off as she looked around the room. I sat on my hands as another researcher quickly picked up the trail by responding: “Recovery can mean something as simple as symptom management, or finding meaningful engagement in community life” and went on to speak to it as a model of approach, not necessarily a promise of cure. Clarity was apparently reached as the researcher with the initial question ended this somewhat awkward moment by closing it with
confirmation that many of the ‘type’ of participants that this project deals with will never fully recover, implying that our type of participants are different than others with mental illness.

Participants were often spoken about as living in another world, a different world: as otherworldly, displacing how their realities are connected to what we have done here on earth. In this way, a long-constructed divide between the curable and incurable body remained despite and because of the rhetoric of recovery. This was not a traditional recovery moment. I recovered myself, as I always did, by meeting the eyes of an ally in the room.

4.2.5 Recovery, Power, and Governance

Considering the shift from liberal welfare-state sponsored and custodial care models for the mental ill, towards neoliberal self-governing community care models, one can see how neatly recovery models fit within the new call for self-governance. Indeed, the critiques of recovery that have emerged recognize the usefulness of Foucault’s concept of biopower (1978) and Rose’s (2007) work on the neoliberal self “to underline the ways in which disciplinary practices such as medicine intersect with neoliberalism by responsibilizing us and urging us to take charge of our bodies and minds” (Morrow, 2013, p. 328). Critical scholarship has emerged which recognizes how the recovery models “of mental health individualize social problems, how they remain embedded in a notion of difference and deficit, obscuring structural causes of distress in the process” (Howell & Voronka, 2011, p. 6). The recovery models, as they have been legitimized and taken up in policy and practice, have shifted in method and meaning, with real consequences:

Whereas twenty years ago resilience and recovery were harnessed as organized frameworks for psychiatric survivors to avert the medical system through alternative means (including peer knowledge and support), they are now harnessed to incorporate psychiatric survivors into medical systems. They now work in ways that attempt to make psychiatric survivors responsible for their own adherence to prescribed ways of governing their interior lives, while at the same time leaving medical authority intact,
since psychologists and psychiatrists have become experts in recovery and resilience. (Howell & Voronka, 2011, p. 2)

The impact of recovery models, as they become best practice in mainstream mental health systems, is not always evident. What was once a way of resisting dominant practices has now become yet another form of governance which rests on techniques of self/governance, which “may not be obvious to many survivors and professionals” (Harper & Speed, 2012, p. 9). Peer involvement and peer work is only now becoming routine best practice, and as it continues to solidify as such, the limits of how power is redistributed is only now becoming apparent.

For example, embedding recovery models within neoliberal governances can work to obscure systemic structural issues by turning them into individual health problems. As Morrow notes, “This ‘healthification’ of social problems fits neatly into the agenda of neoliberalism with implications for the ways in which the concept of recovery is poised to be taken up as an individual journey requiring the ‘manpower’ of the individual to create a healing environment, and his or her family and social support network to provide the engine of hope, devoid of any analysis of the social context in which mental distress occurs and is managed” (2013, p. 329).

Offsetting state responsibility by harnessing informal social network and community supports works as a cost-saving measure. Further, recovery models focus responsibility onto individuals, inviting us to understand marginalization as an individual responsibility. This, as Lemke argues, entails “shifting the responsibility for social risks such as illness, unemployment, poverty, etc., and for life in society into the domain for which the individual is responsible and transforming it into a problem of ‘self-care’” (Lemke as cited in Harper & Speed, 2012, p.13).

Scholars have also noted how “discursive strategies used by neoliberalism undermine social and collective ideas about recovery,” displacing the central role of social and collective movements
The importance of c/s/x social movements in both creating and playing a central role in recovery can be displaced by the ways in which policy and practice takes up recovery. Further, recovery within neoliberal times, by bringing focus

On individual, rather than collective, experience functions to accentuate differences between survivors and indeed organizations. By focusing on individuals the role and potential of collective approaches is obscured. By co-opting recovery, and focusing on individuals, there is clearly a neglect of the social and material context of emotional distress and, in neglecting the impress of power, there is a tendency [towards] voluntarism – the idea that people can simply change through force of will despite countervailing structural factors. (Harper & Speed, 2012, p. 19)

In this way, primacy has been placed on individual rather than social action. As Spandler notes, we must attend to the “potential ways in which social inclusion policies might result in the subjugation of psychiatric survivors through new forms of expert knowledge and power at the expense of genuine collective empowerment and self-determination” (Spandler, 2007, p. 6).

This new approach to managing madness currently sits at the intersection of a number of conflicting and competing fields of power: “Recovery as a concept and a paradigm is poised to either disrupt biomedical dominance in favour of social and structural understandings of mental distress or to continue to play into individualistic discourses of ‘broken brains,’ ‘chemical imbalances,’ and ‘self-management,’ which work against social change” (Morrow, 2013, p. 323).

Within the context of the At Home/Chez Soi project, I argue that it does both, simultaneously. Recovery approaches both work to strengthen funding pitches for social determinants of health investments within communities, yet these policy directives are still based in understandings of individual biological deficit: as the individual with the problem. It does both because the Housing First model provides housing to homeless people (fundamental to foster recovery), yet the participants are expected (with support by mental health teams), once housed, to then move
forward in their own recovery journeys towards community integration, but without structural redress. In this way, one can see the multiple mechanisms of recovery models within dominant and emerging system practices at work within the case study of the At Home/Chez Soi project.

As recovery has evolved in meaning and practice, has it become unrecognizable from its original form? It has clearly been reworked and adapted to fit well with new neoliberal policy and program regimes. Acknowledging that the language and multiple meanings of recovery as it emerges through practice are contested is a first step. Poole argues that querying recovery as it stands and centering “questions about colonizing practices, whiteness, racism, poverty, place and never-ending personal body projects” towards a ‘critical recovery’ is resistance work that needs to be taken up as an ongoing project (Poole, 2011, p. 109). Morrow’s work highlights the need to pay attention to how recovery is deployed through four means: “the language of recovery, a social justice approach to mental health, mental health and social policy, and the role of peer workers in recovery” (Morrow, 2013, p. 331). This last theme, the involvement of peer workers within recovery frameworks, is one of the central ways in which recovery as discourse has jettisoned the advance of peer inclusion within mental health and service systems. Now, to be recovery-oriented requires the inclusion and participation of those who are understood to be recovering. Peer workers, especially peer support workers, have both fought for as well as been invited in to take part in recovery-oriented services. Any recovery-oriented service should employ peer support workers: as individual testament and example that recovery is possible, as governing agents who show draw on the soft touch of commonality to help persuade others to self-govern, and as a cheap form of paraprofessional labour that fits well with the deskilling of labour forces in austere times.
It is noteworthy how recovery, as a discursive field which stemmed from a collective social movement made up of a body of engaged consumer/survivors critical of mental health systems, has shifted. While consumer/survivor involvement is still important, the level of involvement has moved from a collective voice towards individualized involvement without political accountability. This allows for one or two peers to be brought into a dominant system, working from individual experience – and not necessarily a collective experience grounded in the political organizing of the c/s/x movement of the last half decade. Rather, subjects qualified into peer roles are understood as ‘experts by experience’ through individual experiences of mental health issues, and not required to have critical engagements with collective social movements. Our power as peer workers manifests predominantly by attending to ‘similar others,’ not to hold accountable and restructure structural powers. This too can be seen as the ‘healthification’ of peer roles – a transition from grassroots social organizing to the individual experience of governing madness and recovery. This is an important difference that needs to be highlighted: the shift from social movement activism towards individuated peer workers devoid of explicit critical politics.

Further, involving people with lived experiences as peer workers is understood as good treatment practice for those working in such roles. Being a peer worker is understood as a crucial practice within recovery models: employment is a therapeutic intervention unto itself. Employing and involving peers in work positions is understood as a therapeutic intervention that supports the recovery of the peer worker. This perspective is well summed up by Gosling:

User involvement in their individual treatment and care is clearly critical to recovery but user involvement can also contribute to Recovery in situations where users become part of a team or group … People start to feel depended on and needed and gain a sense of responsibility. Their expertise, experience and knowledge are recognized and they become aware of their potential to grow and gain new skills. Gaining positive feedback from interventions such as teaching or consultancy restores a sense of self-worth. Power
and powerlessness begin to shift and the balance changes. Involvement can enable people to feel powerful again and this is part of Recovery. (Gosling, 2010, p. 33)

Through metanarratives of recovery, other discourses morph and tie in to signify new meanings under recovery rhetoric: the language of competency-building, empowerment, hope, and self-direction are a few such examples. Participation through employment, be it consultation paid through honorarium, or full-time peer support work on a clinical team, is understood as a key component to recovery. Participation becomes a therapeutic intervener, and ‘work’ for peers is understood as more than just employment, but also part of their treatment process. Through recovery rhetoric, we come to understand all social activities as psychological ones. As part of our wellness journey, psychologizing work, rest, and play as therapeutic endeavors psychosocialize our inner and exterior lives. Our demands for social inclusion now become crucial for our individual ‘wellness journeys,’ rather than for wider structural reorganizations.

Having mapped how the crisis in representation, participatory models in other fields of governance, social movement resistance, and recovery models of care have all influenced the current participatory turn in mental health service systems, I now turn to focus on how participation specifically within mental health service systems has been written up in literature. I review scholarship that explores peer participation as explicitly the right thing to do; how to do peer participation properly; and the growing advance of evidence-based research that seeks to measure the impact and outcomes of peer participation on providers, service recipients, and peers themselves.
4.3 Part Two: Mapping the Terrain of Peer Participation in Mental Health Systems

In this section I explore the ways in which participation has been approached and utilized specifically within the context of mental health education, research, and service systems. I explore two fields of literature: first, the emergence of texts which work to educate, reform, and set guidelines and best practices for the involvement of PWLE in a variety of settings, from classrooms to service provision to research production. I show how the literature understands the power of peer participation to be individually mediated, offering shifts in the ways in which power is used, yet fails to attend to how the governance of mental illness is further secured through participation. The second set of literature I explore traces the beginnings of a field of knowledge production which works to solidify an evidence base on the effects of peer involvement. I show how peer participation as an activity becomes something to be studied and validated in order to substantiate it as part of the regimes of truth that organize mental health governance. Specifically, I show how peer support work as a new paraprofessional service field in supporting the ‘mentally ill’ is being studied to entrench the efficacy, efficiency, and cost saving benefits of peer participation as an evidence-based practice.

The disability rights and c/s/x movements, the crisis in representation, and the adaptation of recovery as both a philosophy and service model are but three of the many confluence of factors that have been cited as moving forward peer participation into a best practice. Others include the “emerging disquiet in the late twentieth century about the inadequacy and poor quality of welfare and other public services” and the “failure of public services to ensure equal access, opportunities and provision” (Beresford, 2012, p. 24). Further, philosophies of normalization and independent living, the emergence of specific support services for women, racialized and queer communities, and progressive professionals working within the system to change organizational
process have all contributed to the emergence of peer participatory practices (Beresford, 2012, p. 25). Power circulates through peer participation in novel ways, and technologies of power are now being harnessed to discipline and build regimes of truth surrounding how peer participation comes to be.

Recovery has largely been implemented at the individual level, as a way to teach the unruly to become docile self-regulating subjects. Peer workers govern themselves and similar others in order to improve the ways we function in the social and to target personal wellness. What has largely been lost is the collectivist approach of recovery, which targets structural reforms. Modes of peer participation follow similar trajectories. Peer participation has largely meant that peers have been brought in to govern ourselves and similar others through our personal experiences of mental illness. Using our knowledge to dismantle and reform structural systems of oppression is rarely in our job descriptions. Beresford distinguishes between individualist and structural modes of participation by naming the former ‘managerialist/consumerist,’ and the latter as the ‘democratic/emancipatory’ approach. As Beresford notes in his work on the theory and philosophy behind service user participation: “frequent analytical discussion over the nature of participation has been concerned with the ideological distinction between the consumerist or managerialist/consumerist approach, which has its origins in the market-led politics of the new right, and the democratic or emancipatory approach advanced by the disabled people’s and service users’ movements and their supporters, which is grounded in a commitment to collective self-advocacy” (Beresford, 2012, p. 25).

Consumerist approaches have gained favour within neoliberal restructuring in the last quarter decade, and thus “much of the modern discussion about participation has been framed in terms of having choice within a market economy or mixed economy of welfare. The consumer or service
user is thus enabled to decide what (public) service they receive, just as they might expect to have a choice in relation to the commercial provision of other goods and services” (Beresford, 2012, p. 26). Participation through consultation, for example, can be understood as market research, and it thus works to commodify our individual needs rather than “making collective provision for them to secure rights and entitlements” (Beresford, 2012, p. 26). In contrast, a structural approach to participation as generated through social movements sees “participation very much in terms of challenging people’s disempowerment and redistributing power and control … there is a big gulf between the liberatory goals of the service users movements, particularly the disabled people’s movement and its development of the social model of disability with its associations with leftist politics, and right wing consumerism” (Beresford, 2012, p. 26). This ideological distinction is illustrated in the difference between how people choose to self-identify at the individual level: as consumers or survivors.

In Canada, early documents like the Consumer Participation Task Group’s (1998) “Consumer Participation: From Concept to Reality” highlight the impetus and impact of consumer participation to be threefold: improving service systems through consumer consultation (a managerialist/consumerist approach); participation which works towards basic human and democratic rights which also entails “the responsibilities of citizenship” (a democratic/emancipatory approach) (CPTG, 1998, p. 3); and the therapeutic effects of participation on those involved: “making a contribution in this way can increase self-esteem and generate a sense of purpose, qualities which many believe are at the centre of emotional well-being” (CPTG, 1998, p. 4). Tait and Lester’s (2005) U.K.-based work also cites the therapeutic benefits of user involvement by positioning us as experts in our own illness and care needs; we can both “increase the existing limited understanding of mental distress” and “develop alternative approaches to mental health and illness” (Tait & Lester, 2005, p.170); and ultimately
that “user involvement may be therapeutic in itself” and increase greater social inclusion (Tait & Lester, 2005, p.170).

This confluence of the consumerist, structural, and therapeutic benefits of involvement has led to the peer participation imperative, which has particularly flourished in the UK. There, consumerist ideals of participation emerged in the 1980’s and were solidified in 1990 when the National Health Service (NHS) implemented the NHS and Community Care act, which “required local authorities to consult over community care plans and also encouraged user involvement in the process of community care assessments” (Barnes & Cotterell, 2012, p. xvi). The 1990s lead to a flurry of partnerships, strategies and legislation that all strengthened user participation within both mental health service and research, including the 1996 development of INVOLVE as part of the National Institute of Health Research. INVOLVE works in partnership with researchers to ensure public involvement, leading patient and public participation in research to now become an “official policy across the range of NHS and social care research funding programmes” (Barnes & Cotterell, 2012, p. xvii). This means that by the early 21st century, patient and public involvement in research had become a public, researcher and organizational duty. The Health and Social Care Act of 2001 placed a “duty on all NHS organizations to involve patients and the public in planning services, proposals for changes to services and decisions that affect how services operate” (Barnes & Cotterell, 2012, p. xviii). In research, it is now required that “Trusts holding NHS research and development funding have to provide evidence of involving consumers in their research activity as a condition of continued funding” (Hodgson & Canvin, 2005, p. 48).

Not only collaborative, but also user-controlled groups have grown, which have “risen in England from less than a dozen in the early 1980s to more than 600 today” (Campbell as cited in
the British Psychological Society, 2008, p. 1). Legislating participation has occurred not only in the U.K., but also in other countries like New Zealand, where “mental health services cannot (contractually) design or deliver services without transparent and clear processes that indicate consumers are involved in the planning, implementation and evaluation at every level of the service” (Phillips, 2006, 172). Participation in some countries moved from a best practice to mandatory practice, dependent on funding, and peer participation has since flourished. In essence, participatory benevolence through mandatory enforcement (for more on the implementation of service user involvement as policy, see Hunter, 1994; Kemp, 2010).

Much of the work on participation within mental health service and research thus stems from the U.K.. Compared to North America, “England is far ahead and activity in England is systematically developed and implemented” (Frese & Beem, 2010, p. 3). In what follows I review literature that comes from 1) academic and ‘grey’ literature, much written by participants, on how to do participation within mental health systems optimally; and 2) how the domain of mental health participation has generated new sources of knowledge production for researchers aimed at producing evidence-based research that measures the outcomes of such participation. In this way, I show how regimes of practice and truth are constructed and deployed within the realm of peer participation. I purposely explore a broad range of literatures that speak to involvement in mental health research, service systems, education, and consultations, given that the At Home/Chez Soi project was both a research project and mental health service system delivery, and peers were involved in research, service provision, training, and extensive consultations.
4.3.1 Doing Participation Well ‘In the Field’

Much work has been written on how to do participation well. Of note is the plethora of literatures on how to both undertake and improve on peer participation: there are manuals, books, reports, and articles published in both theoretical and mainstream mental health journals that have written the subject up very effectively (see, for example: Building Equitable Partnerships, 2011; Crawford et al., 2002; Felton & Stickley, 2004; Fox, 2008; Rutter, Manely, Weaver, Crawford & Fulop, 2004; Social Planning, Policy & Program Administration, 2012). Here, we see how power/knowledge is shored up and creates discourses, practices and regimes of truth. Yet, over and over again as I worked on the project, I was told that ‘no one knew’ at the beginning of the project how to best implement peer participation. A quick google search will garner plenty of results, yet the hap-hazard way in which peer involvement developed within the project was blamed on a lack of literature. My sense is that a lack of literature was not the issue. Rather, I suggest that planning for peer involvement at the start-up of the project was not prioritized by leaders of the project. Time was rather spent on reviewing literatures that were understood as priorities: that of housing and social policy, community mental health care, working with people with complex needs, comorbidities, substance use, and so on.

When I was hired, I was expected to manage peer participation within the already determined structure of the project. While peer involvement was understood as axiomatic, the responsibility of doing it properly was divested to peers expected to manage our own involvement. Further, my own doctoral research has been continually understood as a project that will inform professionals on how to do ‘participation properly,’ a ‘useful’ project that would result no doubt in a toolkit, a checklist, and some more best practices. My research is continually understood as being directed at how professionals should take us up. In my role as Consumer Research Consultant I sent
references, scanned and emailed books chapters for those who requested guidance: those requests were sporadic. Yet, more was needed. What was useful, I was told, was practical and practice-based. When I vaguely mentioned to one provider that my dissertation wasn’t focused on informing professionals on ‘how to do participation properly’ but rather directed at peers to consider the politics of such participation, I was met with what felt like disdain. Querying participation was useless, even dangerous knowledge.

A 2001 article for the *Psychiatric Bulletin* entitled “Involving Users in the Development of Psychiatric Services – No Longer an Option,” effectively declares a new era in psychiatric service delivery which mandates service user involvement. Crawford writes that “discussion about whether or not users of psychiatric services should contribute to the development of psychiatric services or be involved in planning the care they receive has become redundant. Instead, the time has come to consider how potential problems regarding user participation can be overcome and plan areas where psychiatrists can work jointly with service users in order to address common concerns” (Crawford, 2001, p. 84). With such a call, much has been written on how to do peer participation well. In the early years of this participatory turn in mental health services, Church (1991) produced a Canadian resource book for both providers and survivors that outlined psychiatric survivor leadership facilitation, and some basic guidelines on how to lead meetings that involved consumer/survivors (be inclusive, negotiate meeting times, space, and seating arrangements, provide food, avoid the role of the therapist, and so forth). Following that, Church (1992) explored the dynamics of survivor participation, highlighting both the pitfalls of participation (not enough bodies, no sense of urgency, the fantasy of unity, and too much objectivity) as well as recommendations for professionals (speak up for survivors, lose control, look for barriers to participation, watch your language, and work towards creating safer spaces). Additionally, early work by Croft & Beresford warned how delays in developing
participatory practices within mental health projects hamper users’ power to influence projects, the tensions surrounding how user incorporation can lead to cooptation, and how participation can be a public relations practice that leads to legitimizing organizational actions and tokenism (1996, p. 188). Attempts at addressing such issues are ongoing within peer involvement literatures (see, for example, Robert, Hardacre, Locock & Bates, 2003).

One common practice is to bring people with lived experience into university settings: to come into classrooms to tell their stories and voice their experience, to facilitate a lecture, or to consult and review curriculum (Consumer Participation Working Group, 2003; Simpson, 1999; University of Southhampton School of Nursing and Midwifery, 2002; Wykurz & Kelly, 2002). Extensive scholarship, particularly in the fields of nursing and social work, have detailed the pitfalls of involving services users as teachers (Alain et al., 2006; Baldwin & Sadd, 2006; Basset, Campbell & Anderson, 2006; Lathlean et al., 2006; Reynolds & Read, 1999; Rudman, 1996; Scheyett & Diehl, 2004). The British Psychological Society (2008) developed a document which outlines best practices in recruiting people with lived experience to partake in training, and a document put out by the City University, London, entitled “User and Carer Involvement in Educational Activity,” outlines the ways in which service users can be integrated within course instruction, noting that they should be given “appropriate debriefing, support and training” and should be paid for their work (2008, p. 3).

This text, under the subtitle of “The Professional User,” warns that “there is risk that certain groups or individuals will be ‘over-used,’ for whatever reason. This could lead to boundaries between providers and users being blurred and users losing their ‘bite’” (City University, London, N.D., p. 6). Implied here is the longing for authenticity, that service users drawn into training should be ‘true users’ – the truly mentally ill, and people that are currently and actively
using mental health services – and using users who are ‘recovered’ and/or are too ‘professional’

might mean drawing on users that have developed a ‘soft bite.’ An inability to distinguish us

from professionals risks blurring the distinction between ‘us’ and ‘them,’ and requires the need

for these roles to be performed, distinctly, which leads the authors to ask –“when does a ‘user’

become and ‘ex-user’?” (City University, London, N.D., p. 6) A shelf date for authenticity is

identified as at issue here, despite the fact that biomedicine still promotes madness as incurable

and that “there is no end-date on mental illness” (McMurtry & Curling, 2008, p. 156).

Further, the risk of failing proper representation by drawing on ‘professional users’ (some who,

because of their long-time involvement in representing user views maybe be more politicized)

means that these individuals “may not present the desirable range of views: representatives of

campaigning groups may have axes to grind” (City University London, N.D., p. 6). This issue of

representation is a common theme in the literature, as “professionals wishing to promote user

involvement have frequently expressed concerns about the ‘representativeness’ of individual

services users, sometimes suggesting that particular users may be ‘too well,’ ‘too articulate’ or

‘too vocal’ to represent the views of users generally” (Tait & Lester, 2005, p. 171). This question

of representation and authenticity will be taken up in the following chapter, but Lindlow, in

response to the process of invalidating service users on the basis of representation and

authenticity offers this ‘biting’ critique:

When workers find what we are saying challenging, the most usual strategy to discredit

user voices is to suggest we are not to be listened to because we are too articulate, and not

representative. Workers seem to be looking for someone, the ‘typical’ patient, who is so

passive and/or drugged that they comply with their plans. We are developing our own

strategies to respond to these challenges in an attempt to reveal to such workers their
double standards … We ask how representative are they, and the others on the

committee? We point out that as they are selected for their expertise and experience, so

are we. Indeed, we are more likely to have been selected by a group than they are … We

ask, would workers send their least articulate colleague to represent their views, or the

less confident nurse to negotiate for a change in conditions? (Lindow, 1999, p. 166)
Another developing area of critical reflection is the problem of diversity within participatory practices. Beresford and Bransfield (2012) explore how the intersectional difficulties whenever an identity-based group is formed across a collective identity circulate within the field of peer involvement. Working to increase diversity within a dominantly White participatory base is ongoing, and their study showed that “there was no evidence that groups who tended not to get involved were any less interested in doing so. They simply seemed to face more barriers” (Beresford & Bransfield, 2012, p. 43). Much of those ‘barriers’ often include intra-group racism, homophobia, classism, and ableism. Of particular note is how those who are excluded from participation are often those who have been “relying a long time on services,” and hold “less skills and experience” (Beresford & Bransfield, 2012, p. 43). In essence, those who are understood as ‘too mad,’ ‘too marginalized,’ or who communicate differently are often excluded from involvement. This dynamic ties back in with issues of participatory representation: those understood as ‘too difficult’ to work with are excluded by both professionals and peers alike from participatory privileges. It also then works to dismiss those who are participating as not being ‘representative’ or ‘authentic enough’ to truly represent the views of those marginalized who they have been brought in to represent.

Strikingly absent from this participatory literature is the possibility that ‘people with lived experience’ can and are teaching their own courses in academic settings. This speaks to the ways in which peer participation is imagined. Confined as an ‘add-on’ to knowledge proper, peer participation is limited to knowledge categorized as ‘body knowledge’ derived from experiences of mental illness, rather than as analytic knowledge that authorizes its holders as possessing official knowledges. It reminds me of a moment while in my ‘consumer research consultant’ role when a professor of a prominent university asked me if I had any experience teaching. Being a
PhD student who was also actively teaching a course, I eagerly answered yes, thinking that he had a course in mind that he thought I might be aptly suited to teach. He followed with asking whether I would be willing to come in to one of his lectures and tell my inspirational recovery story. Here, in my ‘peer participation’ role, my knowledge becomes pinned to personal experience of mental illness. I never heard from him. While those working within Disability and Mad Studies have written about the importance of having mad people teach courses about madness and their social movements (Church, 2013; Jones & Brown, 2013; Reville, 2013), this as a crucial ‘best practice principle’ is often overlooked by those working within participatory practices.

4.3.2 Doing Participation Well in Research and Knowledge Production

Another growing area of peer participation is in research production. Clark, Lester, and Glasby (2005) have written on the process and considerations of doing collaborative research across the user/professional divides. Steel (2005) has written on how to involve marginalized people in research, including detailing considerations of time and resources, how to conduct research meetings, language use considerations, and ensuring the recruitment and engagement of ‘hard to reach’ individuals. Leiba, relying on notions of scientism and truth, has written on the different ways in which service users can collaborate within research projects, and cites the benefits for user involvement as including: making research more relevant to clinical practice; improving scientific quality by making the research questions and outcome measure more relevant; and that “user involvement leads to the generation of new and more in-depth knowledge, more truthful information from the research participants, and a better understanding by researchers of the lives of service users” (2010, p. 160).
Leiba argues that early involvement in the planning and proposal stage of a research project “is vital to ensure that service users can be involved in early discussions about the research, because if this does not happen, many decisions about the research may already have been made without the involvement of service users thereby reducing their potential to influence the research project” (2010, pp. 160-161). A detailed point-form outline for “Good Practice Guidelines” is provided, which detail common issues that arise, such as power differentials, language use, training, accommodations and flexibility, and recruiting for diversity (Leiba, 2010, pp. 168-169). Rose has similarly outlined the impetus for collaborative research (noting that there is still resistance to such models in the mental health research field), and speaks to the need to avoid the token ‘tick box’ approach of user involvement, and does so in her own practice by running weekly afternoon clinics with researchers to hold initial discussions on how users can be incorporated into research proposals at the front end of a project (Rose, 2003b, p. 405). This works to “avoid the tokenism of inviting one or two service users onto a research advisory group at the last minute, when a research project has already been established, designed and funded” (Leiba, 2010, p. 161).

Edited books have been published on the practices of doing research by and with mental health services users. One such book, *Handbook of Service User Involvement in Mental Health Research* (2009), edited by Wallcraft, Schrank and Amering, provides both theoretical and practice-based processes for participation in research. The history, context, principles and motives for mental health service user involvement in mental health research are charted (Faulkner, 2009; Wallcraft & Nettle, 2009) followed by some very detailed chapters that outline the complexity of the peer participatory process and describing difficulties that arise in practice. These include reflections on the roles that service users involved in research play (Russo & Stastny, 2009), and the tensions when involved in research between producing positivistic
research with evidence-based research outcomes and survivor research interests, which emphasize research into alternative approaches to treatment, the damaging effects of treatment, involuntary treatment, and cultural issues (Del vecchio & Blyler, 2009, p. 101).

Other chapters provide great detail into how to support user involvement in research by taking into account the larger factors that affect our lives, such as Delman and Lincoln’s (2009) “Service Users as Paid Research Workers: Principles for Active Involvement and Good Practice Guidelines.” Delman and Lincoln outline the planning, preparation and principles that need to be considered prior to launching a research project. These include considerations of how the research benefits service users, and how planning the research with users “can develop a better understanding of the daily lives and hopes of service users, leading to more relevant study questions and outcome measures” (Delman & Lincoln, 2009, p. 140). This means relinquishing control over a research plan and setting the research scope with, and not before, service user participation. Besides the usual suspects of why participation is good – stigma reduction, participator and professional education (as a two-way street), skill development, knowledge sharing, and so on – they also emphasize processes and consideration for involvement that I highlight here because they were similar issues that myself and other peer workers within the At Home/Chez Soi project identified as ongoing issues. Effective hiring practices need to be in place: a clear job description, formal interview and flexible work hours offered, and more than one service user researcher should be hired (Delman & Lincoln, 2009, p. 146). Individualized attention to service users should be made, accommodation needs met, and a supportive infrastructure with flexible deadlines and funding is required (Delman & Lincoln, 2009, p. 147). Again, the authors break down ‘good practice’ guidelines which clearly outline how to do service user involvement well.
Hamilton’s chapter “Money” gives basic principles and practices on how to pay service users involved in research. Of relevance here, Hamilton highlights considerations for those employed who are also receiving some form of state financial assistance. This too was a complication for peer workers within the At Home/Chez Soi project, especially for those working within very part-time or advisory positions, and needed to ensure that their payments for work rendered did not place their government assistance in jeopardy. At times, this required me to have direct contact with benefit providers in order to negotiate ensuring that peers weren’t financially penalized through benefit claw backs or loss because of their work. While rules varied in each province, paying people in cash, which requires organizational access to ample petty cash (petty, implicitly placing our work at the margins) is a requirement. Significant project travel was involved, and so we worked (against organizational operations) to provide advances for travel expenses, but then had to negotiate understandings with state social agencies that these funds were not net earnings but rather expenses. In order to avoid earnings that “may then be deducted from benefits,” speaking directly to the service user, who best knows the rules governing their particular financial situations, is always recommended (Hamilton, 2009, p. 218). Attending to structural disadvantages that prevent and complicate individuals from participating is required as ongoing work (McDaid, 2009).

A review of the literature on ‘how to do participation well’ in mental health and social service systems shows that much has been written, re-written, and revised on how to do participation properly over the last quarter-century. Due to past critiques, the emphasis on participation is now often led with the precursor of ‘meaningful’ as an adjective used to delineate tokenistic from ‘true’ participation. How to facilitate ‘meaningful’ involvement was most of my work as a ‘consumer research consultant’ – to reconcile sustaining inclusionary practices within systems that are fundamentally built on exclusions. I am now positioned as an expert on how to do
meaningful peer participation, and have spoken and written such accounts. As a field of knowledge, it is one that has opened up for us, as well as for those that collaborate with us. Part of the story of the At Home/Chez Soi project is the story of peer involvement, and I and others have publicized the efforts made towards meaningful participation (see Nelson et al., 2015).

One such account, the first scholarly article stemming from the At Home/Chez Soi project on the involvement of peers within it, was written by van Draanen at al. (2013). The article, “Meaningful Inclusion of Consumers in Research and Service Delivery,” is a collaborative work written by researchers and peers involved in the project. Detailing the experience of local involvement within the Toronto site through the formation and sustaining of Toronto’s People with Lived Experience Caucus, the article’s stated purpose is to elucidate how to produce meaningful involvement of people with lived experiences of homelessness/mental health issues in advisory roles through lessons learned in this case study, in order to in future “better plan for meaningful inclusion of consumers” (van Draanen et al., 2013, p. 180). The article is based on interviews and focus groups with both peers and non-peer staff and it develops four main themes arising from the study: issues related to the model of participation, challenges to inclusion, growth and development of the Caucus, and the ingredients needed for “successful engagement” (van Draanen et al., 2013, p. 182).

Much of the findings outlined in the article are similar to issues raised in earlier participatory literatures. How developing a Caucus after “the fact that most decisions regarding the national project were already made by the time the project was rolled out” limited the effect of peer power and influence, as well as issues of clarity of roles, accommodations, meeting spaces, and the ways that professional practices devalue peer knowledge. The model of participation used to formulate the PWLE Caucus is troubled, in particular the ways in which peers were selected, and
again issues of representation are cited as a problem: peers recruited for the Caucus were not understood as similar enough to the project’s study population, which can be understood as peers not being as ‘recently’ homeless or mentally ill the way that project participants were, and thus their advice rendered irrelevant through inauthenticity. Further, a non-peer stakeholder is quoted as reflecting that the peers that formed the Caucus were “a self-select group that came from a very specific … antipsychiatry perspective … and this is not necessarily the representative sample of consumers” (van Draanen et al., 2013, p. 184). Again, there are concerns that critique of the service system by ‘professional peers’ is at representational odds with the general mentally ill/homeless population.

There are warnings in these literatures from services users themselves on the dangers of participation: “when done poorly, involvement can raise expectations and make dummies out of people … Users must be strong enough to resist poor involvement – practice which sets people up to fail, moves the goal post and is much more about professionals’ advancement than ours even when they try to tell us that ‘involvement is so good for you’” (Gosling, 2010, p. 43). Fitting with the managerialist/consumerist approach to participation, involvement can also be conceptualized as “a brilliant survival strategy – turning our problems into a marketable commodity, redefining ourselves and thus shifting the power balance to a more equitable one between ourselves and service providers” (Gosling, 2010, p. 43). The literature explored here is similar to that of participatory development scholarship explored earlier in the chapter – detailing how to resolve the issues of participation within the process of participation itself. Many peers maintain that if participation is done properly, “the process of involvement builds capacity for all partners – learners, service users, provider and educators – we all develop through learning with and from one another” (Gosling, 2010, p. 44).
Through these examples of how peer participation is written up in the literature, we see power/knowledge at play: how to do participation well means attending to power, making attempts at power-sharing, and recognizing power differentials between professionals and other peers. Empowerment, that is working to help peers claim power, is a central goal in peer participation. Recalling Cooke and Kothari’s *Participation: The New Tyranny*, internal critiques to the processes of peer participation are common: the power in peer participation is understood as dispersed through localized interpersonal exchange. Doing participation well in the literature means managing participation by attending to inter and intra-group differences and sometimes, how structural oppressions affect individual subjects. What the literature fails to do is take up the larger questions of how participation itself is a form of governance that allows marginalized subjects to commodify their experience in order to gain entry into systems of power. Once in as people with lived experience, being and staying in cannot be the end goal: inclusion into systems of power is never enough. Rather, “the goal of any antisubordination strategy cannot be the pursuit of respectability. Respectability is a claim for membership in the dominant group: attaining it, even one aspect of it, requires the subordination of Others” (Fellows & Razack, 1998, p. 352). Literatures on peer participation have failed to disentangle how peer participation models work to largely sustain systems of governance, and also how through peer participation, we become implicated in sustaining oppressive systems. As we work to privilege lived experience as a commodity which can translate into inclusion within folds of power, we also have to account for our own agency, complicity, and conflicts within such ventures.

### 4.3.3 Seeking the Science of Participation

The participatory imperative within mental health and research service provision has advanced new regimes of truth. New fields of knowledge production study the impact of peer participation
by investigating whether it produces positive, negative, or neutral outcomes. In essence, a
populistic body of knowledge that explores the effects that participation has on both peers and
professional practice. Thus peer participation has not only grown in literature that speaks to how
to do it well, but also works to study whether peer involvement improves the quality, relevance,
and care of mental health research, education, and service systems. Here, we see how
power/knowledge through evidence-based research is strengthening peer participation as a
technology of discipline.

In educational settings, research investigating “service user and carer involvement within the
education of health care professionals has stimulated a number of initiatives that are developing
an evidence base for the effectiveness of service user involvement in training across a range of
disciplines: in Nursing (e.g. Masters et al., 2002), Social Work (e.g. SCIE, 2004) and more
generally” (British Psychological Society, 2008, p.6). One such study suggests that mental health
graduate students exposed to service users as trainers directly encourages these students as
practitioners to develop similar programs, as “many had implemented user-focused initiatives in
their practice as a consequence of undertaking their studies” (Khoo, McVicar, & Brandon, 2004,
p. 481). In essence, participation begets more participation.

A literature review on the impact of service user involvement in healthcare education
summarizes 41 articles exploring the effects of service user involvement in education in articles
exploring the evidence produced mostly through evaluation studies, findings suggest that
“despite a limited to weak traditional evidence base for impact on students’ knowledge and
practice, both students and service users identify benefits from engagement” and that the “further
development of evaluation methodologies is required” (Morgan & Jones, 2009, p. 82). A lack of
evidence-based research in regards to service user involvement is understood as a problem in need of resolve: an opening for more research needed to determine “which approaches work best, when or why, or under what circumstances successful outcomes can be achieved” (Staniszewska, 2009, p. 295). Positive outcomes that work to justify service user research involvement are cited as needed to continue carrying forward policy and practice. Further, while many U.K. research funders now ask researchers to specify the level of involvement of service users in research grant proposals, “in future such funders may monitor the outcomes of user involvement” to ensure both meaningful engagement and results (Staniszewska, 2009, p. 295). Research that substantiates improved quality outcomes in efficiency, care, and relevance is thus deemed necessary in order to validate participatory investments. Here, we see how regimes of practice and problems of governing produce the need for more evidence-based research to solidify regimes of truth.

4.3.4 Proving that Peer Support Works

The largest growth and professionalization within the domain of peer work has undoubtedly been the birth of the role of peer support worker, which has also garnered the most evidence-based research to support it as an intervention. A role intimately tied to the development of the recovery model of the 1980s, where recovery-oriented support was offered to peers by other peers outside of professional mental health practice, peer support work holds its roots in mutual aid groups such as Alcoholics Anonymous, and offers non-medical support to those in crisis. The MHCC has been a substantive catalyst for working to both legitimize and professionalize peer support work, and defines it in their seminal 2010 report “Making the Case for Peer Support” as “any organized support provided by and for people with mental health problems. Peer support is
sometimes known as self-help, mutual aid, co-counselling or mutual support” (O’Hagan, Cyr, McKee, & Priest, 2010, p. 41).

Peer support work as a paraprofessional field is a fundamental example of how our experiential knowledge is used to govern ‘similar others.’ As a practice, peer support workers disclose and draw on their own experiences of distress to support others, and the key values and processes that peer support workers embody and use in the support exchange include “recovery, empowerment, and hope” (O’Hagan et al., 2010, p. 5). This works to privilege experiences of madness/mental illness/distress as a qualification for employment based on identity and experience. While some peer support is still done on a voluntary basis, peer support workers are now employed and paid as mental health workers in a variety of settings, including consumer/survivor run initiatives, community mental health centres, on psychiatric wards of hospitals, and on Assertive Community Treatment (ACT) teams. This shift, from peer support work as a radical peer-based alternative to biomedicalism towards an offering as official help within clinical professional settings has been a substantive development within the mental health fields, and generates questions as to how the practice of the work changes depending on the environment in which it is employed.

Nevertheless, peer support work legitimizes peer experiential knowledge as a skill, and is slowly staking a claim to become another crucial part of an assemblage of mental health services. With the professionalization of the field comes training (such as WRAP) and expert knowers in the field of peer support. In Canada, the standardization and certification of peer support work is in development through Peer Support Accreditation and Certification (Canada), a non-profit organization launched in 2011, which grew out of initial funding from the MHCC’s Peer Project initiative. Standardization, certification, frameworks, and other measures used to regulate and
manage peer support work in Canada, a process ripe with tensions, will soon be in place, but is cited as inevitable if the aim of peer support workers is to be of equal measure with other mental health professions. One rarely contested question is whether, in fact, the aim of peer support should be to become an equal profession in the field. Further, certification works to consolidate some workers as para-professionals, yet excludes others unable or unwilling to meet training requirements and standards.

There is an investment in the idea of peer support work and few question what power produces through it. The proliferation of peer support discourse and practice has in recent years been harnessed and operationalized to fit within neoliberal austerity strategies of efficacy, efficiency, and state cost-offsetting. As O’Hagan, Cyr, McKee and Priest emphasize in their executive summary for “Making the Case for Peer Support,” “Peer support is effective. People with lived experience of mental health challenges can offer huge benefits to each other. We found that the development of personal resourcefulness and self-belief, which is the foundation of peer support, can not only improve people’s lives but can also reduce the use of formal mental health, medical and social services. By doing so, peer support can save money” (2010, p. 5). Proof of cost-offsets to government spending is gold to policy makers. Peer support work offers a promise of better results, at less expense, and a para-professional role for peers who are often discriminated out of formal employment. Further, integrating peer support workers within traditional mental health settings has been both a way to position organizations as participatory and ‘recovery-oriented,’ as well as to redistribute tasks that other professionals (counselors, social workers) normally do, yet at a cheaper wage. Importantly, on the other hand, it works to undermine the professional status of mental health and social service workers by illustrating how professional positions that are understood as high-skilled and requiring high training can be done by ‘lay’ workers. Peer support work is thus contested terrain, moving power in new ways.
Evidence-based research on how peer support work reduces the use of justice, hospital, and emergency services, reduces distress, and improves quality of life has been undertaken to explore the efficacy, efficiency, and cost saving utility of hiring peer support workers. Moving peer support from the terrain of consumer/survivor self-reliance towards mental health incorporation has produced research that seeks to prove that peer support work can reduce us as problems. As noted in “Making the Case for Peer Support,” “Canadian research has contributed significantly to our knowledge base. Several experimental and quasi-experimental studies have demonstrated not only the benefits to individuals involved, but also to mental health system and communities as a whole, by saving millions of tax-payers dollars through reducing the use of the most expensive types of services” (O’Hagan et al., 2010, p. 5). Seven randomized control trials between 1995 and 2010 have been conducted comparing peer support work interventions with traditional service provisions, and while the findings are inconsistent, a majority of these RCTs report positive or neutral results (Repper & Carter, 2011, p. 396). For example, Chinman, Weingarten, Stayner and Davidson (2001) undertook a study that found that those receiving care from an outpatient programme, when compared with a traditional care provider, had a 50% reduction in rehospitalizations than the comparison group. RCT’s have also shown that peer support can increase discharge rates, support longer community tenure, and reduce the length of bed stays significantly (Repper & Carter, 2011, p. 396). Even when no improved outcomes or change is demonstrated, peer support workers are shown to be as effective as non-peer professionals, as “a result of no difference demonstrates that people in recovery are able to offer support that maintains admission rates (relapse rates) at a comparable level to professionally trained staff” (Repper & Carter, 2011, p. 395).

Further, doing peer support work is conceptualized as therapeutic for both peer support workers and those we act on. A summary of the research findings conclude that those receiving support
from peer support workers promotes “hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks” (Repper & Carter, 2011, p. 400). In sum, peer support works to promote self-governance and normalization through integration. Moreover, being a peer support worker benefits the worker, positioning peer employment as a form of treatment. Literature shows that the “experience of valued work in a supported context, permission to disclose mental health problems – which are positively valued – all add to self-esteem, confidence and personal recovery. Employment as a peer support worker also increases chances of further employment and continued recovery” (Repper & Carter, 2011, p. 400). Emphasized here is the benefit to employment on an individual’s personal wellbeing, rather than employment as relief from poverty and other structural violence.

Within the At Home/Chez Soi project, peer support workers were employed on ACT teams, and also on some Intensive Case Management teams. As the research protocol emerged, consulting peers asked if data on the effects of peer support workers would be collected. As part of my role, I approached the National Research Team with such a recommendation, and a subset of questions were added to the Core Service Satisfaction Scale, asking study participants whether they had contact with a peer support worker as part of their service team, how they experienced this service, and what made this support unique. Likewise, in the qualitative eighteen month follow-up interviews, one probe asked participants if they had received peer support, and if so, to share reflections on the exchange. The project is set to map the experience of receiving peer support from the large study sample, as well as measure the impact of peer support on outcomes such as housing stability, community integration, quality of life, and recovery. Thus the project itself, because of peer recommendation, is now set to establish more evidence-based research on the effects of peer support workers on those receiving services. Here, we see how peers are
working with practices, technologies, and techniques which solidify our role as part of the assemblage of regimes of truth to align with mental health governances.

4.4 Conclusion

In this chapter I have shown how participation is a form of governmentality. It produces particular kinds of possibilities and structures spaces where peer participation both constrains and enables power in complicated ways. I map how the resistant strategies of the crisis in representation, disability and c/s/x social movements, and the recovery movement have together produced new fields of power for subjected identities: the opportunity to govern similar others. The literature on peer participation largely focuses on how to do participation well: what remains to be queried are the conceptual limitations of participation. While participation reroutes power in novel and innovative ways, it fails to disrupt not only the large-scale socio-political, economic and medical investments of the psy disciplines, but also invites peers to participate in practices which sustain and sanction biopowers targeting the ‘mentally ill’ as problems in need of management. In the next chapter, I explore how peer identity is constructed by drawing from participant observation and interview data from peers working within the At Home/Chez Soi project.
Chapter 4

Becoming Peer Subjects: Identity, Authenticity, and Difference

Peer (verb): Look with difficulty or concentration at someone or something; Be just visible; come into view; to appear. Oxford Dictionaries

5.1 Introduction

The previous chapter explored how peer inclusion in mental health research and service systems has now become a best practice. Peer involvement emerged through discourses of community-based practices, social movement activism, the recovery model, as well as new neoliberal governances. The peer subject emerged when lived experience could be harnessed and turned into a useful commodity to access employment. Those of us with experiences of homelessness and/or distress can now market this experience to gain work positions within mental health systems, most often by working with similarly marginalized groups. Significantly, this changed the work that those with ‘lived experience’ do. In the past, consumer/survivors working within community based organizations were focused outward: working to disrupt and challenge the structural organization of service systems. Through the development of peer labour, we now predominantly do affective labour where we work to govern and support each other through individual recovery-oriented care.

Peers working within the At Home/Chez Soi project experience, interpret, and manage their identities in order to negotiate tightly constrained professional space. In this chapter, I draw from postcolonial theory to show how subjects are transformed when invited to represent marginality within regimes of power. Through this conversion, I argue that those brought into peer positions because of their experiences of homelessness and/or mental illness/madness are recalibrated as peer informants. I show how in this process of being brought into mental health assemblages, we
become distinguished from the very population that we have been brought in to represent: the ‘chronically homeless mentally ill.’ This creates a tension and crisis in authenticity in both our own and others’ perceptions of our ability to effectively represent the ‘chronically homeless mentally ill.’

By drawing on ethnographic and interview data, I explore how peers speak about this question of authenticity, of both being and not being concerned with their own representational authority, as well as subjective and active strategies they draw on to make sense of the distance between ‘us’ as peers and ‘them’ as the chronically homeless mentally ill. I then show how being a peer informant is a complicated performance that is full of contradictions. Peer identity is bridge work: to be an effective peer, you must be understood as authentic enough to represent the abject, yet respectable enough to work with and alongside professionals. Peers spoke of mediating their authenticity in a number of ways, including through comportment, language, and dress. This illustrates how being a peer subject is an active process which requires us to perform in particular ways in order to ‘pass as peer.’

Related to this question of authenticity, peers spoke about both the work of creating a universal peer body, and at the same time recognizing the differences that divide our experiential authority due to various privileges and marginalizations. Thus, a strategic essentialism of peer identity is necessary in order to constitute our representational authority: that is, we domesticate internal differences in order to create commonality. Yet at the same time, within this essentialized body, difference fractures notions of a cohesive peer body. Peers spoke of racial, class, and diagnostic divides that forced us to contend with notions of sameness and difference, which works to denaturalize essentialized notions of the peer collectivity. We work to reconcile these differences as ‘diversity’ and ‘variety:’ what is lost is how such differences produce, sustain, and materialize
subordination on particular bodies in significant ways. What emerged through the data is that peers are also learning about difference within the always unstable peer unity, and through this process, we learn who we are and who we are not in relation to other peers. Importantly, this analysis shows that while we are brought in to ‘speak from’ experience, we inevitably, through consolidating our combined experiences through strategic essentialism, end up ‘speaking with’ and ‘speaking for’ Others. We are caught in the same discursive web of representing Others that gave birth to the peer in the first place.

Peer identity is both transient and permanent. While some peers speak of it as a core part of self, others view it as situational, to be assumed when needed. I end this chapter by exploring the risks taken when peer identity is adopted and performed: peer identity can work to reify notions of mental illness. How does playing the peer work to sustain notion of difference rather than problematize them? I argue that while peer subjects work to unsettle who the mentally ill are, at the same time we solidify dominant notions of mental illness as a truth through our corporeal embodiment as peers. And thus, we reproduce the idea of a troubled population that requires intervention.

5.2 From the Homeless Body to Embodied Difference

Competing understandings of the mad subject as biologically determined, as socially constructed and produced, and more recently as a psycho-social recoverable subject have all emerged in the last century. Here, I trace how through the emerging identity of ‘people with lived experience,’ some are able to use this subject position as experiential authority to become peer workers, commodifying our experience to gain entry into work positions. Because accessing a peer identity usually emerges through contact with the psy disciplines, most often peers as a body are understood as those that have lived experience of madness/mental illness. But within the case of
the At Home/Chez Soi project, because the study sample was ‘the chronically homeless mentally ill,’ peer subjects were employed and deployed to represent both lived experience of homelessness as well as mental health issues. Some peers identified as having both experiences, others accessed ‘being peer’ only through a madness/mental illness identity, while still others had been homeless but with less formal contact with the mental health system. ‘Peer’ as a subject-position within the project was thus defined as someone ‘with lived experience of mental illness and/or homelessness.’ This was the criteria for being peer within the project, which subjects had to work to constitute ourselves as authorized to represent. Thus, in what follows I attend to considerations of the homeless body to contextualize how as peer workers within the At Home/Chez Soi project we had to negotiate the particular complexities of representing a specific type of peer, one that embodied the experiences of ‘the homeless mentally ill’.

The ‘crisis in homelessness’ is invoked in ways similar to the ‘crisis in mental health,’ in that both are national crises that are on the rise, and in need of management. As I have shown, when combined, the ‘chronically homeless mentally ill’ as a national crisis is organized as a health crisis – this particular strain of the homeless body are without homes because of their perceived health issues. Samira Kawash’s (1998) *The Homeless Body* provides a crucial analysis of how the homeless body, both materially and symbolically, disrupts how the public and private spheres within civil society are created, maintained, and governed. She shows how the homeless body as an event denaturalizes the duality of public/private space and renders visible how such public and private spheres are constructed and maintained. Homelessness does this by creating disorder by using public spaces for activities officially relegated to the private realm of home. Thus, public space must be regulated and worked on to prevent public space from being used for private means, and “exclusions are justified, naturalized, and hidden by representing social space as a substantial unity that must be protected from conflict, heterogeneity, and
particularity.” (Deutsche as cited in Kawash, 1998, p. 323). The unity of public space, a circular logic whose security is ruptured by digressive use of social space, thus requires evictions of improper use, and the homeless body becomes a prime target of intervention.

Kawash understands the homeless body as an event, and thus

the homeless body is not an identity but an emergent and contingent condition that traverses and occludes identity. I want to emphasize that the ‘homeless body’ is not the same thing as the homeless person or the human body that homeless people necessarily possess or inhabit. Rather, the homeless body emerges as a particular mode of corporeality in contingent circumstances through which the public struggles to define and secure itself as distinct and whole. Such a specification of the homeless body as a contingent and emergent mode of corporeality linked to the contested meanings of public suggests a more restricted analytical framework than looking at homelessness in general as a socioeconomic experience or effect. (Kawash, 1998, p. 324)

Kawash argues that in Western nations, homelessness is created through a hegemonic ideology of separating public and private domains, and “to be without a home is to be without that domain of the private into which the public subject is supposed to be able to withdraw; to be homeless is thus to be thrust into the public without recourse” which produces “an abject body against which the proper, public body of the citizen can stand,” and stand against (Kawash, 1998, p. 325). The constant work of maintaining public space for proper use, and not for private use (sleeping, living, bodily expulsions), invites the creation and maintenance of ‘disciplinary architecture’ and regulations that blocks bodies from the illegitimate use of public space: which in turn reveals how within public space, there is a “symbolic and material distinction between proprietary inhabitants and illegitimate usurpers: in this process, the body emerges as the stake and the site of the contest over public space” (Kawash, 1998, p. 323). As Blomley notes, homeless people engage in public activities which are deemed a public problem, and thus become subject to forms of regulation (Blomley, 2007, p. 55).
Spatial configurations of homelessness are intimately tied to socio-political economies that require abject subjects to facilitate civil ones. The homeless body is not born; rather, it is made and secured through the same processes that foster securing the civil subject: “in contemporary U.S. culture, homelessness is defined in relation to private property; that is, homelessness is houselessness. To be not homeless requires more than to make a place for oneself; it also requires sustaining some tenable position in relation to property” (Kawash, 1998, p. 335). Those that fail to secure respectability become, through systemic encounters, part of the homeless body. Thus, like all subjects, homeless subjects cannot be misread as a natural body: “the homeless body does not refer to an original body, a body outside history or culture” (Kawash, 1998, p. 334).

Similar to mad subjects, they are bodies that are made through the processes that they wear through, and wear them through, and the evictions that dispossess them of officially constructed proper relations of space and place. Keeping in mind that “homelessness in the broadest sense is not a moral or individual failure but a systemic problem that must be addressed in terms of the local and global economic forces working to dispossess and dislocate” (Kawash, 1998, p. 325), the dispossession that results in homelessness as a state of being lands on particular bodies differently. As Kawash acknowledges, “Race, gender, sexuality, age, and class (as well as other complications such as AIDS, drug use, and mental illness) are important factors in who becomes homeless, how they become homeless, how that homelessness is experienced, and whether they remain homeless. Further, even the term homelessness may signal a wide variety of circumstances, from long-term street life to short-term shelter residence to doubling up with a friend or relative” (Kawash, 1998, p. 324). The difference that interlocking oppressions make in how one becomes homeless, experiences homelessness, and recovers from it also influences the ability that one is
able to move such ‘lived experience’ strategically into a peer identity (as well as being mindful of the majority who are unable to move such experiences into a positive peer identity).

Kawash argues that the usual identity markers of difference can be undone by the particularities of the homeless body as a condition. She goes on to suggest that

at least in the case of the urban street dweller, the particular contingencies that are typically read as marking one as homeless are not skin color or sex, but other attributes such as dirty or disheveled clothing, the possession of carts or bags of belongings, and particular activities such as panhandling and scavenging. In public space, the homeless do not appear as individuals with distinctive identities. Under certain conditions, homelessness effectively eclipses such socially defined particularities. Thus, as it is ideologically and materially constituted in relation to the public, the homeless body must be seen as a specific mode of embodiment, one that requires its own specifications. (Kawash, 1998, p. 324)

What are some specific modes of embodiment of the homeless body? The homeless body represents a crisis to public security, yet in ways different that the crisis in mental illness. Homelessness is often visible in public space, whereas mental illness is a crisis that is often invisible, and perceived to permeate all space through corporeal embodiment. Cox’s work on identity and madness shows how “expectations of sane behavior vary across communities and identities; most people’s expectations of the ‘sane’ behaviour of a middle-aged white woman differs from their expectation of the ‘sane’ behavior of a teenage African American male. In fact, the ability to pass as sane does not depend on a singular set of criteria for sanity. Rather, passing as sane requires that a person refrain from breaking the social norms regarding other aspects of that individual’s identity” (Cox, 2013, p. 105). In thinking through how this applies to the homeless body, the ‘chronically homeless mentally ill’ and Aboriginal homelessness in particular are two types of embodied conditions that depend on traditional identity markers to differentiate the particularities of the homeless crisis specifically by relying on identity as a problem that produces such crisis. In the social imagination, both the homeless mentally ill and Aboriginal
homelessness produce a specific ‘homeless body’ - and a particular threat - that is different precisely because of these identity markers that Kawash argues can be subsumed when conceptualizing the homeless body.

For instance, Aboriginal bodies in urban public space threaten our security in particular ways as a white settler nation, and remind us that the enforcement work needed to sustain this land as white is ongoing. As Razack notes, “dispossessed and then divested of control over their own economic, political and social life, Aboriginal people are never incorporated into settler colonialism as full and equal members. Rather, they are incorporated as a conquered people, under surveillance” (Razack, 2011, p. 102). Surveillance includes the policing of public space, a spatial process which produces encounters “that colonial society must anxiously manage both in policing and in law, producing settlers as owners of the land and Aboriginal peoples as dispossessed; each comes to know himself or herself within these practices” (Razack, 2011, p. 103). Aboriginal bodies occupying urban public spaces, especially in parks, sitting on sidewalks, idling in transit stations, while not analogous, are entangled in association with the homeless body in ways that white bodies are not, even if as individuals they are not experiencing homelessness. Aboriginal bodies are made out of place, read as occupying space and breaching spatial segregation systems when daring to use civil public space as their own – they are bodies out of order. Any resistance in abiding to white settler regulated civil uses of public space by sleeping, drinking, or loitering requires intervention: As Razack notes, “the public nature of Aboriginal life, such as drinking in parks, itself an outcome of dispossession and colonization, become punishable in law” (Razack, 2011, p. 102).

Statistics circulate that show that Aboriginal homelessness in Canada is a crisis (Leach, 2010). How is it made possible that Indigenous peoples in Canada are divested of land? How can people
indigenous to this land become homeless? Confronting such questions would force us to interrogate the tenets through which we secure own safe relations to space as settlers. Instead, Indigenous peoples and homelessness become entangled identities when transgressing into public realms that have been marked as white civil space. I argue that a body that is read as Aboriginal in public space need not be accompanied by a shopping cart, disheveled clothing, or waving a cup full of coins to be marked as homeless. Rather, a body read as Aboriginal in civil public space is enough to evoke the homeless Aboriginal body, a body not at home, and thus identity markers of race and culture are actually intricately tied to particular typologies of the homeless body. Razack argues that “Aboriginal people haunt settlers in ways that other abject populations (homeless alcoholics, for instance) do not. It is their land and taking it continues apace” (Razack, 2011, p. 119). The Aboriginal as homeless is a particular haunting that threatens to force us to remember our ongoing labour of securing this land, of ongoing attempts at marking Indigenous peoples as displaced from this land, and being viscerally confronted with Aboriginals out of place in public space sanctions responding to them as trespassing against the social contract.

I am reminded of contestations within the At Home/Chez Soi project as we worked to solidify the definition and parameters of what constituted a ‘peer identity,’ and who could occupy such work roles. Several Indigenous people argued that all Indigenous peoples come to the table with ‘lived experience’ of homelessness and/or mental health issues: even if not experienced individually, the collective experience of dispossession, displacement, and trauma, positioned all Indigenous peoples with an intimate knowledge of both homelessness and mental health issues, and thus all Indigenous people should be able to occupy peer roles within the project. It is a reminder of how individualizing Western conceptions of ‘expertise by experience’ are, by placing primacy on individual rather than systemic collective experience. Other Indigenous
people argued that there is a difference between collective and individual experiences of homelessness – that those who have slept outside, been incarcerated in psychiatric wards, been through mental health and social service systems, bring forward a particular knowledge of how such systems work, knowledge that can only be gained through individual experience. In the end, individual experience over collective experience was the requirement needed to enter into a peer position for the project.

Again, ‘the chronically homeless mentally ill’ as a particular strain of the homeless body deserves attention, especially since it is one that evokes such public concern. When subjects occupy public space in ways that signify their bodies as mad (seemingly one-sided conversations, hostility, unusual appearances), these markers too are entangled with associations of homelessness (and always race). They are bodies out of place, bodies that are supposed to be spatially regulated to the institution, or at least vigilant surveillance. Concern that such bodies are not properly governed, and are allowed to occupy public space without restriction, invokes a fear, and usually a fear of violence. If they are bodies that appear as disheveled (similar signifiers to the broader ‘homeless body’), and thus bodies that are not in their proper space, I suggest that associations of visibly mad people to the ‘homeless body’ are often viscerally made. Mad people, after all, are conceived as poor, in crisis, may be off psychiatric drugs and on street drugs, and generally conceived of as unable to maintain themselves to the attributes of civil society (home, work, family, love). Such assumptions are tied in particular to relations of private space: mad people are not understood as able to maintain private property; rather, they are public holdings relegated to state interventions and systems. A subject read as mad on the street is more likely to be read as homeless, even if they are not, because they are not contained as they should be. As Mills notes, subjects are often brought into being through a visual encounter: ‘seeing’ the ‘mentally ill’, which rests on “the assumption that these homeless ‘mentally ill’ people exist on
the streets, yet are ignored by society; they both exist and do not exist in the eyes of society. Or we could say that a particular way of looking (both the ‘look’ of the psychiatrist and the disheveled ‘look’ of the homeless) enabled certain people on the streets to be identified as ‘mentally ill,’ bringing them into being as such, without them even having to step inside a clinic” (Mills, 2014, p. 83).

While a general homeless body is certainly marked by attributes of street life such as panhandling, can collecting, shopping carts and disheveled appearance, the markers of Indigenous and mentally ill bodies in urban public space evoke particular risks – even if the individual subject isn’t homeless – to the public which shows how intricately entangled race, disability, and the specter of the homeless body are (for more on entanglements of race and disability, see Chandler, 2013). Thus, while Kawash’s assertion that “the homeless body is not an identity but an emergent and contingent condition that traverses and occludes identity” (Kawash, 1998, p. 324) is an important point, in practice state interventions rely on identity markers to intervene on particular identities within the collective homeless body. Both Aboriginal homelessness and the homeless mentally ill are specific risks targeted within the homeless body that require and enact precise neoliberal health and social policy interventions based on identity. The At Home/Chez Soi project is a prime example, targeting those that meet the definition of ‘chronically homeless.’ Further, to qualify for the project all participants had to be discerned as mentally ill. Within specific regions of the country with high concentrations of Indigenous peoples, Aboriginals experiencing homelessness were targeted, recruited, and supported in ways different than the general homeless body. The “public struggles to define and secure itself as distinct and whole” (Kawash, 1998, p. 324) against Indigenous and mentally ill threats to civility take particular form, based on the particular problems Indigeneity and the mentally ill pose to ongoing white settler nation building projects.
In practice, this meant for subjects to be recognized as peer workers within the At Home/Chez Soi project, we had to attempt to embody the complex and conflicting ways in which these crises are conceived and managed. At the individual level, for a project targeting ‘the chronically homeless mentally ill,’ people with lived experience brought in to be peer workers had to contend with not only recognizing themselves as subjects with experience of distress/contact with the mental health system, but also struggle with representing homelessness, and variances across intersectional modes of difference. This created paradoxes and tensions for peer workers in how to effectively embody these crises, especially when they went beyond their own embodied experiences.

5.3 Peer Subjects through Biopolitical Neoliberalism

Willse argues that “the life guaranteed by the invention of chronic homelessness is not the life of those populations most directly organized by it. Rather, the ultimate investment of chronic homelessness is in those populations that most benefit from the wellbeing of neo-liberal economies” (Willse, 2010, p. 179). Paradoxically, one consequence of the economic management of the chronically homeless mentally ill body is how through such economies, the peer subject has emerged as a possible figure. And through this subject-position, some have come to benefit from such new forms of governance. If neoliberal biopolitics no longer concerns itself with the redemption or annulation of such a population, why has ‘the peer’ as viable labour and a redeeming figure in mental health and homelessness assemblages appeared? I suggest that it is precisely this turn from managing degeneracy as a social problem toward an economic investment that has allowed the peer subject to become.

As I show, peers transition from abject bodies into peer subjects through employment roles within this ‘non-profit industrial complex.’ Neoliberal mental health and social service
economies, in combination with seemingly contradictory social justice discourses such as the recovery movement, the crisis in representation, and social activism have converged and merged together to allow the peer subject to emerge. The opportunities that neoliberal economic investments through population management strategies generate also need to be cushioned and supported by the communities on which they intervene. Enter the peer worker, a bridging subject that at once works to represent community interests and profit from mental health and homeless economies. Further, austerity measures rely on deskill labour that formally was understood as highly skilled and professionally regulated work (research scientists, psychiatrists, nurses, social workers). By downloading the more menial tasks that professionals do onto peer workers, professional expertise is still maintained, while the more menial tasks of the professional are now performed by peer workers at a reduced cost. In this way, peer subjects have been made through both progressive social attitudes and conservative economic tactics alike.

Further, ‘peer’ as an identity is a liminal space which works to complicate the binaries of ‘respectable’ and ‘degenerate’ bodies and populations. As I show in this chapter, we are at once degenerate because of our experiences of marginality, but are working to become respectable through using such experience to authorize it as expertise to intervene on ‘those like us.’ We help to define the population that we are intervening on by organizing ourselves as ‘people with lived experience,’ and further help manage the population by entering into peer work roles. Through this process, as peers we become invited in to govern through colonial improvement projects (for more on colonial improvement projects, see Razack, 2015).

As discussed in previous chapters, critical theory has written extensively on the how processes of interpellation recruit and constitute subjects. Althusser mapped how ideology, interpellation, and subjecthood are simultaneously working together so that “ideology has always-already
interpellated individuals as subjects, which amounts to making it clear that individuals are always-already interpellated by ideology as subjects, which necessarily leads us to one last proposition: individuals are always-already subjects” (Althusser, 1971, p. 176). Importantly, Foucault showed how emerging scientific explanations for subjects worked to both subjugate and constrain individuals by being defined through the narrow scope of scientific fields, yet simultaneously how such subjection creates opportunities for resistance by organizing around new identities. Mills’ work considers in particular how psychiatric diagnoses can create psychiatrized subjects through recognition: how “‘even the most noxious terms could be owned… the most injurious interpellations’ can be the site of ‘radical recuperation and resignification’ . . . Although, in occupying the ‘discursive site of injury’ in order to resist it, such identity politics invoke a ‘self-colonizing trajectory,’ a paradoxical attachment to the injurious term that has called one into being as a social subject, the term that enables one to exist (Butler, 1997, p. 104). And thus one may become attached to the psychiatric terms that bring them into being, even if these terms enact an injury, even if they are violent” (Mills, 2014, p. 77).

As I’ve discussed previously, some subjects refuse being recognized as a scientific and biological problem, and adopt what Foucault would identify as resistant identities, mobilizing against the cohesion of the mentally ill subject.

This shift in possibilities of becoming is new: madness in the past century has been understood as a scientific body, a social activist body, and now, through the peer subject, as an economically viable one. The peer subject is an assemblage of both resistant and dominant identities that have been forged together to produce a cohesive peer identity that allows us entry into work roles. Before I started working for the project, my own resistant mad and psychiatric survivor identities were frameworks I drew on to make sense of my experiences. By the end of the project, I
strategically deployed a peer identity to authorize both my own and others power positions within the burgeoning economy of peer employment.

My interviews with other peers show a similar process. Some came to a peer identity by understanding themselves as mentally ill subjects. Others, as consumers and recovering from various states of being (psychosis, addiction, homelessness). Still others had harnessed social justice-oriented identities (Mad, psychiatric survivor) to explain themselves. Regardless, all of these various subject-positions and their accompanying subjectivities are recruited and able to organize under a peer identity. As Noorani notes, “What unites both the consumerist subject position of the service user and the oppositional subject position of survivor, is that they are granted authority by virtue of their experiences of mental distress and/or of service (ab)use, and seek progressive developments in the treatment, perception and governance of the experiences of mental distress” (Noorani, 2013, p. 52). Both resistant and dominant identities that organize around experiences of the psy disciplines are hailed and recognize themselves under the new peer order. By recognizing and reconfiguring experience into a peer identity, a subject can resignify a devalued identity into an economically viable and more respectable one.

5.4 Recruitment: Becoming Peer Workers

The peers that I interviewed spoke of becoming peers through activity: through recruitment. Notably, of those that I interviewed, most had little to no knowledge of the consumer/survivor/ex-patient and mad social movement prior to coming into a peer position. That is, the peer subject is an individual who recognizes themselves as peer through their individual experiences, and not necessarily through social movement activism. The peer subject is, in this sense, a long way from the social movement activism that preceded her. The entry point into a peer identity is strategic, an essentialism that can turn a usually denigrated subject-
position into a useful commodity. Those that I interviewed spoke about coming to peer identity through a variety of active processes. Anne spoke of her first foray into peer work while still a patient in a hospital, recruited by a provider to work as a peer on a participatory research project. In this way, she was recognized by professionals as a potential peer worker because of the space that she occupied. Similarly, Bob reflected on how he was approached to be a peer researcher while living in a transitional housing facility. Lee spoke of how she “came into peer work by personal experience. And in that, in my journey into healing, I became aware of peer opportunities and was given opportunities for training as well, and learning more about peer work.” Here, Lee recognizes herself as a potential peer worker through her individual experience in combination with ‘people with lived experience’ as a newly available identity circulating within the mental health systems in which she was embedded. Thus, the spaces that we occupy as degenerate subjects (clinical and social service settings) where ‘peer work’ as a discursive possibility is available helps us to recognize ourselves as potential peers.

Others spoke of doing peer work out of necessity: that is, because of systemized discrimination against behaviours associated with madness, adopting a peer identity was an economic strategy that allowed subjected subjects, by recognizing themselves as peers, into emerging labour markets. Debbie spoke of a ‘ceiling’ for paid roles that she could get because of employers discrimination, and May of working in a peer role as “the only job that I could get hired at.” Sally spoke of starting to work in peer roles as she “had been out of the job market for like five years so I was still learning and recovering psychologically” and peer roles facilitated her transition back into work. Here we see how peer work roles allow those that have been cast out of traditional employment positions to reenter the workforce by harnessing peer identity.
Others spoke of being recruited through informal networks: Veronica told of how she was recruited into her position by others who suggested she would suit well for the work because “A lot of people know that I had been homeless and that I had mental health issues and that’s not something that I hide. I’ve never hidden that from any of the employers that I went to work for.” Similarly, Heyoka spoke of how she came to use her experiences to facilitate entering into a peer research role: “I got a phone call from a friend who worked with my organization and said that he knew of something that might apply to me. So I called in and scheduled a meeting with my boss now. And I came down, it was a very informal interview. I brought a resume. My friend was aware of my history. And so when I spoke with [future boss] I was very open about that, and he was also open about indicating that that would be useful and relevant to the research. So I was hired without much of a – it didn’t even feel like much of an official interview. Like, it was very casual and it just worked out: suddenly I had a job.” Here we see how experiences of homelessness and of mental health systems/distress as common knowledge are turned into a qualification which orients particular bodies towards peer work, and thus, peer identity.

Paul was the only peer who explicitly spoke of becoming a peer by being a part of the consumer/survivor movement, and his interest in peer support work developed as a result of such activism. Clair, already having an elaborate history of drawing on her experiences to do advocacy work in various NGO settings, spoke of how she became a peer worker for the At Home/Chez Soi project:

Well, I saw a notice on the Commission website looking for local committee members and they were looking for, I don’t remember how they phrased it but they were looking for people with lived experience and I thought this was a great opportunity to get involved. Because I do have experience of homelessness and mental health issues, so I just wrote an email sort of describing just a brief outline of my background, that I had been involved in different peer work in the community, as well I have this background of homelessness.
Organizations now need peers in order to sustain intervention projects, and peers are harnessed through participation as assets into the assemblage. People order themselves as peers for a variety of reasons. Some that I interviewed identified as mentally ill, others as consumers, others as survivors, others still as mad. Yet all were able to set aside the particularities of how they self-identified to recognize themselves and respond to being hailed as peers. Thus, participants spoke of making sense of their ‘lived experience of homelessness and/or mental health issues’ in strategic ways, ways that facilitated them into neoliberal biopolitical economies generated by marginality.

Jackson’s narrative unpacks how the emergence and expansion of peer work has changed the ways in which people with lived experience work within health and social service sectors. Jackson marks how the emergence of the peer and peer work has fundamentally changed the way that community-run organizations are conceptualized, funded and run. She describes how, in the 1990s, prior to the mainstreaming of peer work, community organizations that were survivor-run businesses or heavily employed people who had contact with the psy disciplines were run as community economic development initiatives. Under such frameworks, the work that was done “wasn’t really about us, as much as it was about them. So it was highly politicized on that level, it was completely understood that the reason that we needed to actually do what we were doing was because of the threat that was posed by the low rate of employment or the lack of access to opportunity. Or the fact that people were so ground down by poverty. But it was never individualized.” Working under a psychiatric survivor identity for community organizations was understood as work that was directed at critiquing and changing structural systems, rather than managing our own: “any work that I did with the community was like an act of resistance, and not at all one of bending to what somebody else wanted.” In this way, Jackson notes a shift in how ‘peer’ has reoriented the work that those marginalized do: a shift predominantly from
‘outward’ work that was directed at structural systems change, towards predominantly ‘inward’ affective labour which focuses on supporting each other.

Jackson notes that over the last two decades, with the emergence of the recovery model, biopolitical neoliberalism, and peer identity and peer roles, the work that community organizations can do has changed. Through the development of ‘peer,’ Jackson spoke of how the organizations have shifted from “grittier” workplaces where the common thread was that “we’re all fucked up and that’s why we can share this space” as we work on changing the system, towards working on problematized populations, where peer work emerges as the individualized work of sitting “beside my peer and talk to them about what was going on for them. And like really kind of support them, to be able to realize their own potential because I was someone who had been there.”

This shift from external social justice work to internal psycho-social work has changed the labour that community organizations can do. Jackson notes that while it has actually increased the amount of some community organizations funding, especially through the ability to access mental health grant opportunities that are framed as recovery-oriented, it fundamentally alters the labour that gets done. “That’s been the shift, right. It’s like once you actually have [peer] language that is imposed on you about the work that you do, your work automatically changes whether you like it or not. So all of those community economic development initiatives are now social enterprises. No, we never asked for them to be seen that way, and similarly none of the work we ever did was peer work.” Yet, ultimately, that’s what becomes possible for community organizations to survive under biopolitical neoliberalism: the work becomes population management through peer governance. Jackson notes how currently, peer identity has changed the ways in which both dominant and resistant identities made possible through the psy
disciplines organize. She notes “how deeply we’ve bought into the notion, like there’s this interchangeable way we talk about being engaged in the world, and for survivors it’s all about peer work. The ability to be politicized about the work is so limited … I think that it’s like, in the world, in a capitalist context, people are always going to find ways of making money.”

5.5 The Making of the Peer Informant

As individuals who are brought into intervention projects, peer work must act as bridge work. Our bodies work, as bridges to, to connect fractured lands. Peers work to bridge the divide between abject and respectable bodies. As peers, we need to be both. This is complicated identity performance. To be a peer you have to pass as ‘authentically peer’ to professionals, to the homeless mentally ill, and to each other as peers. On the one hand, we have to negotiate ourselves both as street authentic enough in professional fields, yet still remain professional enough in such settings to remain incorporated. On the other hand, when working with clients, we have to perform our marginalized experiences so that they are rendered visible to the client. We also have to be recognizable to each other as peers. These are different demands than when other marginalized workers move into professional fields. Nirmal Puwar’s (2004) *Space Invaders: Race, Gender and Bodies out of Place* shows how racial and gendered others moving into professionalized fields must disavow their difference in order to secure their presence in the workplace. She shows how difference must be denied when racialized women move into white male professional spaces, for “the cost of coexistence is erasure or, in other words, as Fanon (1986) says, become white or disappear” (Puwar, 2004, p. 152). She argues that although ‘black’ bodies in predominantly white spaces are incredibly visible as different, they are also under assimilative pressure to conform to the behavioural norm. They are expected to take on the ways and means (social codes) of upper/middle class whiteness. Adherence to the norms and values of this hegemonic culture is almost a condition of entry. Those who are able to speak what Bourdieu (1992) has referred to as the
‘legitimate state language’ and what Fanon (1986) has termed the ‘imperial-mother language’ are more likely to be allowed into ‘civilized spaces.’ (Puwar, 2004, p. 150)

Unlike the process that Puwar describes, where difference must succumb to normative codes to secure inclusion, peers must do both. They must both follow the social codes of professionalism, as well as bring forward difference of thoughts, approach and embodiment. Peers should both breach and sustain hegemonic codes of professional conduct in their roles. To maintain a peer position, peers must learn when to reify difference, and when to subsume it.

Given that peer identity is unstable and needs to be continually attended to, issues of authenticity arose for peers as they performed their roles. As subjects are hailed into the assemblage, we are reconstituted. This process of being an outsider brought in to shed light on and represent particular subject-position knowledges, and what it produces (how it changes an individual’s subjectivity, the limits of what they can convey, as well as the dynamics of what is discursively produced through such acts) has been well theorized within post-colonial work. In this section I attend to post-colonial critique as it pertains to bringing outsiders into assemblages in order to represent them.

Edward Said draws on the word ‘interlocutors’ to describe this process of what happens to subjects when outsiders are let in to the fold. Interlocutors within colonial contexts can be someone who speaks and acts as an informant to the occupying power, yet also “someone who, like Fanon’s native intellectual, simply refuses to talk, deciding that only a radical antagonistic, perhaps violent riposte is the only interlocution that is possible with colonial power” (Said, 1989, p. 210). Said’s rich description of the process of becoming an interlocutor within current community activist or academic goals of emancipatory change he details as such:
In this context the interlocutor is someone who has perhaps been found clamoring on the doorstep, where from outside a discipline or field he or she has made so unseemly a disturbance as to be let in, guns or stones checked in with the porter, for further discussion. … If such a description of interlocutor appears somewhat caricatural, it does at least retain enough of the denaturing incorporation and cooptation that are, I think, required for such interlocutions to occur. The point I am trying to make is that this kind of scrubbed, disinfected interlocutor is a laboratory creation with suppressed, and therefore falsified, connections to the urgent situation of crisis and conflict that brought him or her to attention in the first place. It was only when subaltern figures like women, Orientals, blacks and other “natives” made enough noise that they were paid attention to, and asked in so to speak. Before that they were more or less ignored, like the servants in nineteenth-century English novels, there, but unaccounted for except as a useful part of the setting. To convert them into topics of discussion or fields of research is necessarily to change them into something fundamentally and constitutively different. And so the paradox remains. (Said, 1989, p. 210, italics mine)

Being invited as an interlocutor into these scenarios when one is expected to speak from, representing a with, at a large table of dominant Western models of understanding, indisputably and immediately changes one’s subjectivity from an outsider to an outsider-in, and immediately the dominant conditions of what can be said, what can be known and done, and what is allowed to be heard, are irrevocably changed.

Trinh has described this condition of being invited in to represent the other as a process by which both respectable and degenerate identities are reconstituted. Applying this to peers, we are only invited in by respectability, and thus need “to acquire good manners for the membership standing.” Our admittance and performance of peer requires us “to partake in the reduction of itself and the appropriation of its otherness by a detached” dominant discourse where the terms of inclusion have already been set. For peers, this process is both “uplifting and demeaning,” being both celebrated for our difference yet singularly reduced to it as what authorizes our speech and presence (Trinh, 1989, p. 67). Professionals, who set the terms of inclusion, through such co-mingling are also made anew: as Spivak notes, “the banality of leftist intellectuals’ lists
of self-knowing, politically uncanny subalterns stand revealed; representing them, the intellectuals represent themselves as transparent” (Spivak, 1999, p. 257). In this way respectable subjects are made anew through their associations with degeneracy.

When a stranger subject is asked to speak of their subalternarity, the subaltern becomes someone else anew, and transitions into a native informant. Gayatri Spivak’s work on the production of the native informant is crucial here. Spivak characterizes in *Can the subaltern speak?* the native informant to be the third world woman—“the typecast of the foreclosed native informant today is the poorest *woman* of the South” (Bhatt, 2001, p. 2) although in later work she notes that this position is now being supplanted often by figures such as postcolonial migrants, ‘benevolent cultural nativists’ and ‘self-marginalizing migrants’ (Spivak, 1999). Spivak’s argument in *Can the Subaltern Speak* is that the moment that the subaltern is brought in to the fold, they are no longer able to speak as subalterns, but rather as “gendered outsiders inside.” Spivak notes that “For the (gender-unspecified) “true” subaltern group, whose identity is its difference, there is no unrepresentable subaltern subject that can know and speak itself; the intellectual’s solution is not to abstain from representation. The problem is that the subject’s itinerary has not been left traced so as to offer an object of seduction to the representing intellectual … [thus] with what voice-consciousness can the subaltern speak” (Spivak, 1999: pp. 272-273)? These native informants are “much in demand by the transnational agencies of globalization for employment and collaboration” (Spivak, 2000, p. 9), but their ability to speak authentically from alterity is negated because in the moment that they are brought in to speak, their subalternity ceases. They become someone and something else. Thus, “when a line of communication is established between a member of subaltern groups and the circuits of citizenship or institutionally, the subaltern has been inserted into the long road to hegemony. Unless we want to be romantic
purists or primitivists about “preserving subalternity” – a contradiction in terms – this is absolutely to be desired” (Spivak, 1999, p. 310).

So the question is reframed from can the subaltern speak (no), to how can the native informant act best and be heard given the limits of what is required of them within this native informant position. Jane Su Chaun Ku’s work, *Producing the Native Informant: Third World Immigrant Women’s Activism and Self-making Practices in the Immigrant Services Sector* explores just how “the native informant exists in a limited but contested position. She is regulated by a series of paradoxes and by being forced to choose between binaries in order to produce herself as an authentic Third World subject” (Ku, 2003, p. 80). The native informant must foremost always represent herself as authentic to the imagined marginality that she represents, which is of course compromised because she is never unmediated by forces outside of that ‘native, untouched site’ for which she has been brought forward to the table to speak of. As Ku notes, “The individual must successfully represent herself as an unspoiled authentic native voice to stand in for the whole of the Third World in speaking for the First. In doing so, practices of authenticity erase her lived realities, and spatial and temporal inequalities. In this way, she becomes less threatening among the [other] ethnics, and is a preferred stand-in (Razack, 2000). . . . Sometimes, she must be more Westernized in orientation, and confine her critique to marginalia rather than comment on the processes and inequalities between North and South” (Ku, 2003, p. 84). She is not free to speak of the effects of empire on her experience, for that in turn would compromise her status as authentic and decenter her from her authority to speak as a native informant.

If the native informant is to speak about the West and its implication in her lived experience, she can potentially be dismissed for holding self-interest that is Western, and hence her native purity is cast into question. The conditions of her speech are “contained through paradoxes and binaries
which prevent unsanctioned speech from becoming meaningful or legitimate in the Western-dominant field ... The demand for "authenticity" is the dominant mode through which the Third World subject is intelligible and audible. As an authentic subject, she must be uncomplicated, transparent and unitary without contradictions or multiplicities" (Ku, 2003, p. 81). She can never complicate her essentialized nature by voicing the ways in which her lived experience has been penetrated by Westernization, and in this way limits have been placed on her self-representation. Thus, the demand for authenticity from native informants is “a strategy of disciplining immigrant women in their performance as the native informant, [and] thus their activism” (Ku, 2003, p. 81).

The native informant is thus able to navigate this position within tight confines:

- the demand for authenticity places the native informant on the defensive, always operating within the margins and continually forced to claim the right to speak, and to speak with power and authority. The native informant is drawn into a “reactive defense of an identity that [she] might not have defended in [her] ‘home’ countr[y]” (Khan, 2001, p.21). She emphasizes her Third Worldness only in relation to the West. The demand for an authentic and transparent stand-in produces an inability to differentiate the speaker from the marginalized community. It assumes the coincidence of the interest (or the investment) of the speaker with that of the community she “represents.” Yet, the interest of the native informant is always in danger of being revealed as different or self-centred because of her Westernization (and any other differences that allow her to be constructed as unlike her authentic community). In navigating this fine line between Western corruption and authenticity, she is given a “special” status (Trinh, 1989) when she follows the native informant script. When her speech is not necessary or when she becomes dangerous, she is then considered to be too corrupted by her Westernization (Trinh, 1989). (Ku, 2003, p. 85)

Given the limited conditions of how the native informant can speak and be heard, what is the best way for her to proceed? Ku comments that “speaking as an authentic universal third World voice is the only way the native informant can be heard. A similar strategy is used by various counter movements. For example, through universalizing the subject, the feminist movement has been able to claim an essentialist identity of “woman” and thus unity of interests and experiences among all ‘women’” (Ku, 2003, p. 93). As discussed in Chapter One, “speaking from” works to
essentialize and legitimize subject positions and experiences as truth, and not as constructed and constrained imaginary figures that are produced through the limits of discourse and the effects of socio-historical conditions. Thus, the native informant is limited to voice experiences that are comprehensible to Western audiences, as well as “how she is allowed to interpret those experiences. How she interprets her own experiences must be understood in the context of what interests and knowledges are possible … In these ways, claiming authority of experience is also a highly problematic strategy for gaining power of speech” (Ku, 2003, pp. 96-97). In order to conduct activism within the confines of the native informant position, one must exploit the experience of the subalterns and enrich herself with “the surplus value of the oppressed” (Ku, 2003, p. 95).

Within the case study of the At Home/Chez Soi project, peers brought into the fold experienced a similar paradox in authentically representing the homeless mentally ill. While some peers clearly identified with the experiences of this archetype, once invited in as peers, they are no longer the homeless mentally ill. Upon entry, they become peer informants: in being brought in through formal means to represent, they leave behind what they were. Being offered the opportunity to voice, they are no longer the voiceless. They are now speaking on behalf of the voiceless. How is becoming the peer informant managed? How do peer informants, who have been brought in to speak from experience, manage this transition into realizing that they are not in effect speaking from but rather speaking for? In the following section I attending to how peer informants negotiate representing under new conditions.

5.5.1 The Peer Informant and Authenticity

How do those invited in to represent those with ‘lived experience of mental health issues and/or homelessness’ negotiate this transformation into peer informants? Given that the abject is
unpresentable, do peer informants, in their transformation into peers subjects, note a tension in
their authority to represent subjects that they are now distinguished from in their new roles as
peer informants? Do peers question their own authenticity and authority to speak and act for
those that they have been hired to know and represent?

Some of the peers I spoke with did not express a crisis in authenticity. These peers did not report
feeling unauthorized to speak and to represent as ‘the chronically homeless mentally ill’.
Veronica noted that “even though we were not diagnosed with the same problem” she tries to put
herself “into their place because that’s where I was at one time or another … So I know how it
feels, so I pretty much try to fight as if it was me.” Norman too felt comfortable representing the
homeless mentally ill and found “similarities” between himself and “that target group.” Other
peers spoke about recognizing a disconnect between their own experience and those that they
were representing, but working to make sense of that difference. As Clair noted on the
differences between project participants and peer workers: “for me I really wanted to have the
authenticity, that was important to me and that was something that I did think about.” She spoke
of how she felt that she “could relate to that, the transition into being a housed person and having
to rebuild your life. But the experiences that many of the participants have had, of being hardcore
homeless for many, many years and rough sleeping on the streets was not my experience so I
didn’t relate to that. And I did feel at times that I wasn’t a true peer to some of the participants,
and that I wasn’t sure I could really represent them well.” When I asked if that stopped her, she
said “No, it didn’t stop me, no. I still felt there was enough from my experience that was
valuable that it was still useful.”

Peers spoke about figuring out how to work through this question of authenticity and
representational authority. Sally spoke of how when she “was first involved in the project I really
had no clue about poverty … I felt really stupid. I don’t know anything about homelessness, I am sorry. And I said to the [boss] I was working for, I feel completely dishonest, like why am I here as a person with lived experience if I don’t have the lived experience of the participants in the project?” But as she got used to working in a peer role, “then I came to see lots of areas of commonality, like how addiction was a big thing.” She spoke of how it “was a big responsibility to act on behalf of people with mental health issues” and when asked whether it felt like too big a responsibility she replied, “Yes and no. But sometimes I feel the responsibility, so I have to like blank my mind.”

The contradictions that peer workers face by being brought in through the authority of experience became apparent when they recognize that their own singular experiences cannot be essentialized into a universal experience of homelessness/distress. Peers had to reconcile this contradiction, so well-illustrated by Spivak and Said’s work, by positioning this tension as necessary in order for them to help others. That is, we are seduced by notions of the ‘helping professions:’ that our help as peers is better than what other helping professions offer. Thus, we work to process, subsume, and rationalize the differences between self and other in order to proceed with our work. We are also seduced by our own investments of our self as redeemable, and part of our redemption is through ‘giving back.’ Crucially, we gain access to the powers of respectability and professional expertise through intervention work that pins others as degenerate bodies.

This contradiction persisted throughout the interviews: this feeling of both being and not being authentic is exemplified in Heyoka’s reflection that the main difference between project participants and peers is that “I’m employed. You know what I mean? Like it’s a paper-thin difference. I have a stable home and I’m employed. But I’m not really a different person than
they are … And so, I don’t know. I don’t know how much of a separation there is. I mean, of course there’s a separation. A lot of the people that I talk to have had a lot more consistent trauma in their lives that I have, but, I don’t know. I still feel able to connect with them.”

Similarly, Lee understood her experiences as authorizing her current work. When asked if she felt secure representing participants she said “I think I definitely can because I can remember my struggles. I remember how I felt. I remember. Those things are things that won’t leave me.” She notes that being in a peer position now allows her to draw on past experience to act as a translator to those without lived experience: “I’m in a better position now to explain it to others. And explain the processes and I’m more understanding to why people can get frustrated and am able to explain what’s happening through somebody’s thought process, or the barriers that they keep coming up against, and running into walls, and what that does to a person.” Lee understands herself as a peer subject who is positioned to explain the homeless mentally ill subject to professionals because “I’m still connected with that. And I would be able to portray it or explain it to others.”

At the same time, peers had plenty to say about having their own authenticity questioned, and how that is related to conceptions of the ‘the chronically homeless mentally ill’ as an unknowable archetype. Lee recounted how she had “heard that I’m only 50 percent person with lived experience, and I don’t know what that means … There’s a hierarchy. There’s a distinction. I don’t know. But I see myself as 100 percent person with lived experience.” When asked to explain, she spoke about how peers were recruited into their positions, how they were conceptualized as “people that are in drop-in centres, using the services, going to food banks, things like that. That’s people with lived experience.” Because she had previous experience “working in the community, having done research, then I’m not a person with lived experience? They weren’t looking for me.” She notes that this confining understanding of who ‘authentic’
peers are, and who they are not, leads to limiting recruitment to spaces where professionals think peers are: “They just automatically think about drop-in centres.”

Jackson importantly tackles this longing for authenticity from both peers and professionals alike by dismantling “this reified completely romanticized idea of a crazy person that deserves an opportunity.” She notes how through this elusive quest to find “escaped mental fucking patients” and turn them into peers, that the archetype of the chronically homeless mentally ill as obscure, dangerous, and risky is solidified. She notes how in the project’s quest to “make sure our [peer] researchers reflect the participants in our project, which is the craziest motherfucking line I have ever heard in my life,” it overlooks that “there are a lot of mad people out there, and a lot of them are doing just fine. Like why pick the most broken people that you can possibly find? Like, is that about legitimacy? Like, what is this fetishization of broken people as being the face of your consultation and your inclusion?”

This fetishized idea of who project participants are as the chronically homeless mentally ill impacts the ways in which, as peers brought into represent them, we think about ourselves in relation to both respectable and abject bodies alike. As peers, we come to understand our experience as ‘less than’ those that we are supposed to be representing, in a way minimizing our experiences over those that we imagine others to have. Anne spoke of how “there was always this kind of feeling” that “it’s like a bit of a privileged position to recover.” And those that are in such positions account for the possibility of recovery because their experiences are imagined to be less severe than the chronically homeless mentally ill. Anne goes on to say how “I was only briefly homeless. I lived in a shelter, so I don’t feel that I have had that experience and I actually felt [that] on the [local peer group]. That composition, it’s a little bit, like there are people that have not experienced homelessness, and I feel that’s really a particular situation.” Bob too spoke
about feeling “dishonest” about “claiming that I am a peer with this group,” while struggling to cope with the difficult situations that some of the project participants were in. “Eventually you look around and you’re like, I don’t feel like I’m a peer. Like I understand the population, like I can understand what’s happening. But when you’re actually doing the work, it’s harsh. Like just whoa—going into people’s rooms and having, like there’s blood everywhere and drug deals happening and all that kind of stuff. The impact was really, really too much for me.” In this way, peers in proximity to others lends to reconceptualizations who we are as peers, and who we are not compared to others. We learn who we are and who we are not, not only in relation to encounters with professionals, but also in relation to the ‘chronically homeless mentally ill.’

Rachel spoke at length about questioning the representational authority she held as a peer: both through her own conflicting conceptualizations of self, as well as how she was invoked by others. She spoke of how “I felt quite defensive from the beginning, as though I was going to be found out as a fraud” because her own experiences as well as previous peer work that she had done were situated in middle-class settings and circumstances. She noted managing a constant tension and I didn’t really know how to discuss that and how to approach that, but I felt as though any minute I was going to be found out … And so I think a lot of me thought that I wasn’t necessarily the right person for the job, even from the beginning I felt weird about that. But you know, I’ve talked to a lot of people I used to work with and this feeling of being a fraud is present and it’s not just me, and I find that a relief as well. I feel as though we’re supposed to perform things in a way, that a peer on a team is supposed to be a certain way, is not supposed to be well educated, is not supposed to have this or that language or critical thinking skills. Their role is supposed to be the person who stands up for certain issues and says certain things, and it can be tiring to be that person … I think there’s a real perception of what a peer is and it varies from place to place, site to site, project to project, but people imagine what they want their peer to look like and what they want their peer to do.

Rachel also told the story of being in a social situation where she introduced herself as a peer when meeting someone else in the social service field, and “he said, ‘well, no you aren’t.’ He said, ‘you’re not a peer.’ And I said, ‘well, then I guess we’re approaching the word peer
differently,’ and because he works every day in the [inner city area] was like, ‘a peer worker is someone who was in the [inner city area] and is now doing enough with their life that they’re acting as peer to other people, like that is what a peer is.’” She noted how this was “an extreme example of someone telling me, ‘no, you’re not a peer.’ Mostly that didn’t happen, mostly that was in my head, but I still had a very weird negotiation of my role … And so in this person’s mind I was not a peer in that sense even though he didn’t know anything about me, he’d never met me, he was just looking at me and decided that I wasn’t a peer and that I clearly didn’t have a serious problem or a drug problem or whatever it was I was supposed to have had in the past in order to qualify as a peer.”

Jackson notes that discourses of what makes a peer ‘authentic’ are mobilized by both professional and resistant groups alike. She highlights how professional organizations are “fucking trying to puppeteer the most authentic experience,” but at the same time more radical formations, “like mad activist types, would hate to have a mad person out of university” representing them. They speak of how mental health organizations and those working against them are often conceived of as at polar ends of a linear spectrum, as oppositional, but when it comes to authenticity “they are so close in their fear of their politics, of who they are, that you realize that it’s not fucking linear. That there’s not like the most radical at one end and the most elite at the other. In this case it’s circular, like the elite and the radical kind of have the same idea” when it comes to who the chronically homeless mentally ill are, and who are fit to represent them as peers.

Jackson goes on to note how conceptions of the authentic chronically homeless mentally ill are outdated, because recovery and resilience models of care have altered how such subjects are now constituted, and “the system is churning out a very different version” of the abject subject.
Further, she notes the troubling ways in which such universal conceptions of who the chronically homeless mentally ill are relies on understanding them as a stable, fixed, permanent abject body: “what it actually does is it sees them as unmoving, because it doesn’t understand that the person in the university could have been the [chronically homeless mentally ill] person at some point. Like there’s a whole life that gets you there, and it can actually be completely similar to the life of the person who managed to, via completely coincidental decisions, end up like saving them from that. Like they’re the same fucking community of people: it’s an inability to kind of conceptualize that.” In this way, Jackson is pointing to how ‘the chronically homeless mentally ill’ are conceived as fundamentally constituted different against normalcy, which works to sustain them in the public imaginary as forever fixed in their degeneracy. And if they so emerge, they are no longer authentic enough to represent that which they were.

5.5.2 Passing as Peer: A Performance

Peers also recognize that they play a game of passing. Because peer subjects work to bridge respectable and abject bodies, to be rendered recognizable as peer subjects we have to simultaneously be different from and the same as both abject and respectable bodies. We have to be both at once. We have to distinguish ourselves as both respectable enough to work alongside professionals, and abject enough to connect with participants. Passing as peer is a complicated process. To be a ‘good peer’ we have to be good at embodying our ‘recovery journeys’ and self-manage our madness. This is work that disabled people more broadly are familiar with, as we have learned when to draw out our marginalized difference, and when, if possible, to conceal it. As Brune and Wilson note in their 2013 edited volume Disability and Passing: Blurring the Lines of Identity, the question of disability and passing is two-fold: at times, a subject can work
to pass as ‘normal,’ at others times, one has to work at passing as disabled. In regards to disability passing:

Most often, the term refers to the way people conceal social markers of impairment to avoid the stigma of disability and pass as ‘normal.’ However, it also applies to other ways people manage their identities, which can include exaggerating a condition to get some type of benefit or care. Going further, disability passing encompasses the ways others impose, intentionally or not, a specific disability or non-disability on a person … nearly all disabled people confront, often routinely, the choice of hiding their disability or drawing attention to it and the question of what to do when others overlook it. Going to the root of a disability identity, their decisions weigh issues of stigma, pride, prejudice, discrimination, and privilege but rarely put the matter to rest. (Brune & Wilson, 2013, p.1)

Passing as normal and passing as disabled both have serious material consequences. For some, passing as normal is a requisite in order to, for example, sustain employment or relationships. Passing as disabled can be crucial for those working to secure and sustain disability benefits or supportive housing. For peers subjects, we have to pass as normal enough to work as peers in workplaces, and disabled enough to effectively authorize our authority.

Peers are acutely aware of these contradictions, a juggling of conflicting signifiers that at once worked to signify both respectable and degenerate qualities. Rachel spoke of the competing demands of trying to be professional enough and authentic enough to represent the peer body. She spoke of an encounter with a former co-worker who said “to me that I had spoiled them because I had acted in a way that was more conventional” in the peer role. She reflects, “I guess I was easier to deal with, because I was more like a practitioner and less like a peer. People say they want one thing, but maybe they want the other thing. They say they want authenticity and they say they want to be pushed in their thinking, but that’s hard. I think a lot of people end up appreciating being pushed. … In general people like to be pushed, but at the same time if you can get away with having a peer who is acting in a more conventional way, then that’s easier.” In
this way, being difficult is ‘authentic’ and translates to performing your role as a resistant peer, and being easy positions you as ‘co-opted’ and translates to performing your role more compliantly, as a conventional worker. As Rachel notes, both the easy and the difficult peer are desirable. The difficult peer offers the authentic experience, the easier peer offers less workplace challenge. Most peers spoke about learning to be both: difficult at times, and easy in other times.

Peers often have to mark their peer identity, to render visible what may not be easily read. Bob spoke about acquiring their peer position in part because he was a blend of both authentic and respectable – “sort of like, you present well and you can speak fairly well, so you’d be a good face in this project.” Anne spoke of “bringing up the peer thing as quickly as I can” when working in a peer role. She notes how “it’s really hard to figure out how to present yourself, and I also feel because I always get ‘but you don’t seem like one, you know.’ So that identity issue is big with me … then it comes out as almost like, I try to wear my wounds as much as I can … and mention all of these things right off the bat quickly” so that she is recognized as peer.

Often, when I was working, I found myself over-announcing my peer identity, often prefacing my remarks with, “speaking from the peer position …”. When in familiar company, it was a way of showing that I was doing the work that I was brought in to do. When in new company, the strategy was broader: by announcing my peer role at the table, usually done during doing introductory rounds at the beginning of a meeting, I identified myself as peer through my work title, ‘consumer research consultant.’ This worked to announce that ‘the chronically homeless mentally ill,’ the subject of discussion, of which all work was generated from, was amongst them. I harnessed that announcement in the hope that it would alter the discourse that followed. That is, I hoped that the ways in which the subject of conversation was spoken would be less detached, denigrated, problematized. That my presence would recalibrate the ways in which
professions organized their speech around ‘the chronic homeless mentally ill:’ from scientific language of ‘us’ as a disease towards recovery-oriented language of ‘us’ as human. I also made much of my peer status in unfamiliar company to protect myself from the ways in which they speak of ‘us’ when they think that ‘we’ are not in present company. Professionals have yet to acclimatize themselves to the fact that they may be in ‘mixed company.’ By making much of my peer identity, it becomes their labour to carry, to alter the ways in which they work with language when doing their work.

This issue of recognition – of needing to be recognized as peers, by both professionals and participants alike – was mostly spoken about as managed through appearance. How does a peer appear so that they are recognized as both authentic and professional enough in professional settings? At the same time, how do they perform so that when working with project participants they are recognized as similar others? When rendering visible as peer in professional settings, peers invoked questions about how those that they were supposed to represent should look like. Paul spoke of how “At times I wonder if I should appear more damaged. Dirty clothes, or smell a little. It’s silly, hey? Or as a peer, I should hold the stereotype of a person who is suffering.” Bob too asked, “do I have to dress shitty and like gash my face” in order “to be understood as a peer, as someone who can relate to the population?”

In professional settings, peers have to present in ways that will allow them to be understood as both authentic enough and respectable enough. Lee spoke about altering her appearance in order to gain authority in professional settings: “when I was realizing that I wasn’t being heard, I thought it was the way I dressed. And so I started to do a little more business casual in terms of the meetings.” She spoke of getting dressed up to attend professional events, and having professionals come up to speak to her:
saying ‘hi, how are you,’ and looking in your eye. I know what’s going on in their head. They’re thinking – ‘oh, she dressed up for this event.’ They looked relieved. And so when I saw that I kind of just made sure that I be that way at the [professional] table. But then I wasn’t comfortable. And I learned, when I dressed comfortably, I’m more comfortable. So I kind of did a mixture between jeans and business casual. I’m comfortable with that. But yeah, it did make a difference. It was noticeable. I noticed it.

While peers spoke about dressing up in order to fit in at professional tables, they also reflected on how that conflicted with being recognized as authentically peer. Many peers spoke of having to present themselves as both professional and authentic, and mediating their appearance in order to fit the circumstances. Bob spoke of adopting professional wear in professional settings, and also going more casual when working with participants: “Like I was definitely more dressed up and felt more comfortable being dressed up in that [professional] setting. Where I would never, never ever go into [participants homes] looking that way. I just wouldn’t. That would be so awkward and strange really for me. So yeah, I definitely thought a lot about that.” Bob also noted the discrepancy between ‘dressing for success’ and ‘dressing to represent,’ markedly asking, “who are we trying to please, you know? Is it the people we’re working for or is it the people we’re working with?”

Peers also spoke of numerous professional encounters when they were compelled to change their subjectivities in contradictory ways. The project was well funded, and involved a lot of privileged perks for those working within it, including travel, hotel, and dining experiences that worked in sharp contrast to the lives of chronically homeless mentally ill that we were working with. I had to ‘study up’ by learning how to dine in fine restaurants, stay in lux hotels, and become a frequent flier. These were both privileges I enjoyed and felt ashamed of, and it fundamentally changed who I am. There is a deep irony in experiencing the most professional privilege I’ve ever held by fore-fronting my abjection. Heyoka too spoke about this conflict of
earning privilege through representing marginality, noting “I would have huge guilt pangs going to these hotels and having a dinner when I could comprehend how much a single plate would cost. When I knew I was going to go back to work in two days and talk to someone who doesn’t even have welfare because of their mental health challenges. It made me feel dirty. It made me feel like the rich people dragged me in to be complicit in their stupid gluttony.”

Heyoka also spoke in detail about the ways in which she would put herself together for work in an effort to accommodate both the demands of working with both participants and professionals:

I try to dress on a daily basis like I’m ready to meet someone who’s living under a bridge, and also like I might meet a member of the legislative assembly. Because that has happened, you know, where I’ll meet a City Councillor or someone who’s a CEO or something, or political figures; and in the same day I have to meet, you know, a participant. … I’m not trying to pick people up, so I’m not putting on a lot of makeup like I might normally want to in my day-to-day life. I tend to keep my bright stuff for the weekend. And that goes to my clothing too and my clothing is really muted. I have not worn anything red or purple in a long time. I don’t want excitable clothes on me. I tend to keep with the cool greens and blues and greys and blacks and more subtle things, browns. And I try to dress with style but in clothing that I acquire generally at thrift stores or very cheaply.

Peers also spoke of modifying their presentation in order to better fit in and read as relatable when working with participants. Rachel was sure that there was “invisible work that I did: changing my language, changing the way that I talked about things. Yeah, and not being overly academic.” Bob spoke of how he “would consciously kind of maybe change my behavior a little bit. But more as far as like physically, like if I would slouch, like that kind of stuff in order to get people to feel more comfortable.” When I asked Paul if he modified his appearance when doing his work with participants, he said no, asserting that “the manner that I comport myself rests pretty close to the same, yes.” His presentation wasn’t an issue for him, and he remained casually
dressed in his peer role, laughing that he had “no jewelry” to hide. But Sally noted that “considering we are working with participants who are living in poverty and everything you don’t want to come in with your diamonds, not that I have any diamonds. But you know what I mean. But I find that it’s a bit irritating because it’s, I don’t know – it’s dishonest.” As peer informants then, we recognize that there is a difference between us and those that we represent, and have to work to minimize that difference in order to read as relatable to the chronically homeless body.

That the peer subject is a socially constituted and mediated construct that organizes experience into essentialized difference is rarely discussed, because it threatens the naturalization of difference that our representational authority requires. Some peers are aware of this, and are ready to trouble the peer subject as a given identity. As Rachel notes,

> I realize that we have to have discussions about what it means to be a peer. It is not a given, you can’t take it for granted, you can’t assume that everybody feels the same way about it. You shouldn’t be guessing how everybody on the team feels about the fact that they have a peer at the table or what to expect the peer to do or not do. I think that a lot of my discomfort could have been solved by frank, honest discussions and I think there just wasn’t enough honesty and some of it was on my part, I’ll own that. I was afraid of being a fraud and then some of it was just on other people’s part. Like, what is this thing, what is this job description, what is this title, what does it mean?”

In this way, peers are actively reflective of juggling the performance required to pass as peer, and in doing so, raise questions which denaturalize the essentialized notions of a peer authenticity.

5.6 Making the Unified Peer and Dealing with Difference

Peer work relies on the premise that lived experience of homelessness and/or distress creates a universal body of knowledge that can be represented and consulted. Peers worked hard to construct notions of ‘commonality’ in order to solidify our authority within the project. We also
worked to deconstruct notions of the universal peer, raising questions of how a diversity of differences of privilege and marginality within the peer collective fracture any possible ‘common experience’ that people who have been homeless and/or had contact with the psy disciplines universally share. In The At Home/Chez Soi project, tensions in particular around the authenticity and representation of peers in relation to the study population that we were brought in to represent – the chronically homeless mentally ill – manifested in a number of ways. These included whether peers had been homeless, and if so, if they had been homeless ‘long enough.’ As well, what kinds of mental health and addictions issues peers experienced mattered. Questions, presented by both peers and professionals alike, of whether those in peer positions were ‘crazy enough’ – usually by drawing on diagnostic criteria-- to truly present as ‘peers’ to the population under study continuously circulated. Further, issues of interlocking oppressions presented: how do white settlers speak to issues of Aboriginal homelessness? How do race, gender, ethnicity, sexuality, culture and other identity politics fracture notions of common interest, representational possibility and peer unity? In essence, in our will to power we have constructed peer participation based on notions of a shared collective identity. Inevitably then, we also confronted how this shared collective identity was fractured along other divides of difference.

Peers have a vested interest in disavowing internal differences as the acknowledgement of difference undermines the idea of the authentic peer. Several peers spoke of this dilemma. Paul reflected on the difficulty of producing the voice of peer consensus: “When we represent, personally what I find complex is ‘speaking for the cause,’ and making sure to say good things. That is complex work. When we speak, we want to bring a common voice, and when I speak, that voice is filtrated by my own course [of words]. It’s difficult, in any case, it is work that I think is the most difficult that we have to do.” Some peers spoke of strategizing to subsume
individual difference through collective process. Ken spoke of the necessity of strategically organizing more generally around shared oppression than getting into the differences that can work against the notion of a unified peer: “I think for me it’s that analysis of oppression that can be a really helpful starting point, and then creating a critique based on that. I think it’s a lot more consumable than trying to talk about identity, community and culture. Because that requires people to call themselves something, right?” In this way, the effort to focus on common oppression, and disregard differences amongst peers, is the work required to produce the unified peer collective.

As I have explored in earlier chapters, the troubling of representational authority, of whom can speak for whom, has led some scholars to argue that we should only speak from our own experience. Alcoff, arguing against such a stance within the context of the feminist movement, offers a critique of this standpoint approach to speaking experience:

We are collectively caught in an intricate, delicate web in which each action I take, discursive or otherwise, pulls on, breaks off, or maintains the tension in many strands of a web in which others find themselves moving also. When I speak for myself, I am constructing a possible self, a way to be in the world, and am offering that to others, whether I intend to or not, as one possible way to be. … When I “speak for myself” I am participating in the creation and reproduction of discourses through which my own and other selves are constituted. (Alcoff, 1991, p. 21)

Inevitably, then, when one speaks from your own standpoint, you are still caught in speaking for others, as you are contributing to possibilities of being through discourse. In turn, when negotiating the representational authority of ‘the peer’ as an individual subject, you have peers turning again away from speaking from their own ‘lived experience’ towards relying on speaking from and for a collective voice as peer informants in order to account for variances of ‘lived experience.’ In essence, the individual peer informant is authorized to speak and represent on behalf of others. Being peer authorizes one to speak on behalf of othered others. Paradoxically
then, under the formation of speaking from a unified voice, the practice of ‘speaking from’ lived experience is displaced – the call which sanctioned us in as peers within the assemblage in the first place.

The issue of ‘speaking for’ is never resolved through the inclusion of multiple voices. Multiplicity can simply mask hierarchical relations among peers. To grapple with this contradiction, and to sustain notions of a universal peer collective, Ken argues that we should be ‘speaking with.’ This depends on the logic that if a large enough representational mass of peers assemble, then saturation will be met, and representational validity achieved. As he notes, “it’s again, getting out of the individualized thinking about ‘I’m representing these people.’ Well, you’re not the only person representing. You’re a part of a group of people that’s been developed, to do work, and that’s what organizations do, right. They bring different perspectives together, different knowledge bases and then, that’s why they are able to produce work.” Within notions of a peer unity, we collect and collate multiple experiences as well as our own, and end up speaking on behalf of ourselves and others. Thus, the issue of ‘speaking for’ is never resolved through the inclusion of others. In this way, the differences amongst us become understood within a variety framework, a variance from the normative peer, rather than emphasizing how the differences amongst us account for very different experiences of discrimination and oppression. This is because ‘people with lived experience’ describes collective bodies with an experience (mental illness/homelessness), rather than understanding how subjects become constituted by experience.

The dilemma of who gets to be a part of the peer unity – and thus who gains access to employment roles – is also always in question. Anne spoke this trouble in the context of developing a peer group, and working on guidelines that discerned what characterises were necessary to qualify as ‘peer.’ Because usually denigrated attributes have now become desirable
under the authority of peer participation, we currently have to sort through questions and contestations of who gets to be a peer. She found that while developing guidelines there was pressure to expand qualifications from ‘severe mental illness’ to cover a wider scope, including addictions and trauma. She notes that this broadening of who gets to be a peer creates a “huge umbrella and we stretch it so far that it means that everybody is underneath it. And I guess that can be great but then you lose the distinctiveness of the groups and the particularities and difference which is important. … I have different challenges and different issues that may be similar to someone who’s you know recovered from trauma. They don’t have like freaky paranoid moments, or maybe they do, but whatever, it’s particular … So far it’s been kind of brushed over and now I guess we’re just including everybody.”

This question of who qualifies as peer matters, because it determines who is able to access the power of resources that are now offered through peer identity. In my own work, a big tension was how family members of ‘the mentally ill’ were actively working to claim peer identity in systemized and structural ways. Family members claim ‘lived experience’ because they have a loved one who experiences distress, and they often advocate on behalf of their family member (a process which can happen through the law, where the family member is legally allowed to represent a mentally ill subject if the mentally ill subject is legally deemed ‘lacking capacity’ and unable to represent their own interests). But being a family member is not equivalent to having the experience of distress/homelessness. Indeed, a family member’s interests can often be in direct conflict with those experiencing distress. I raised such representational issues in my role, and used my own experience to illustrate: I spoke of how as a mad person, I want to have control and choice over my own self and treatment options. Yet as a sister, I often wished my brother would comply with psychiatric and psychopharmaceutical
recommendations, as it would make my life as a family member easier. Thus, my advocacy as a sister was very different that my own self-advocacy.

This issue of family members fitting under the umbrella of peer grows as the move to professionalize peer support work proceeds. Family members working to support other family members want their work to be recognized as peer support work. As the move to certify, systemize, and regulate peer support work as a profession grows, family members supporting other family members have a lot to gain by being recognized as peer support workers: a profession. Myself and others argued that such work is distinct, and should be named something else – family support work. Because the language of ‘peer’ has come to mean something other than simply “a person who is the same to another”: but rather, as I have shown, through recovery discourses, ‘peer’ within mental health and wellness fields now specifically works to signify those with shared experiences of mental illness/madness/distress. But family members as individuals and organizations disputed such distinction, and mobilized within the MHCC. In the end, in MHCC official documents, peer groups, and as a representational authority, family members came to be recognized as ‘people with lived experience’ through hereditary association. Further, who gets to be a peer will continue to be a contested site as long as it continues to provide and entry point towards accessing power.

5.6.1 Proximity and Difference

How do peers deal with difference within the peer unity? In Strange Encounters: Embodied Others in Post-Coloniality, Sara Ahmed argues that the Other’s difference can only be produced and confirmed through proximity. Drawing on Robin Cohen, she shows how identity is produced through encounters with difference: that is, “social identity is continuously constructed and reshaped in its (often antipathetic) interaction with outsiders, strangers, foreigners and aliens –
the ‘others.’ You know who you are, only by knowing who you are not’” (Cohen as cited in Ahmed, 2000, p. 100). Ahmed asks, “how do contemporary Western subjects enter relations of proximity with strangers and become transformed? . . . How are ‘strangers’ consumed? How does the consumption of strangers involve a transformation in the subject who consumes” (Ahmed, 2000, p. 115)? Argued here is that the consumption of stranger difference allows the dominant subject to know, process, become, and take what is of value from the stranger, and discard that which is deemed a threat to Western dominance. Noteworthy here is that peers, while organized as a category of Others outside of dominant status, still within this subgroup learn off of each other’s difference. We learn who we are and who we are not against other peers through proximity.

A number of peers spoke of learning off of difference through contact with other peers. In particular, non-Indigenous peers spoke about the value that the proximity to Indigenous peers gave them: it offered lessons, about residential school systems, the ‘60s scoop, and the cultural organization of Indigenous peoples. Peers reflected that one of the benefits of working for the project was that it allowed for a proximity to peers of difference that they otherwise don’t have access to encounter in their lives. Peers also spoke about learning to work with those with criminal convictions. Claire spoke of her initial reaction in learning that a fellow peer that she worked with had substantial criminal convictions for sexually violent offences, and she initially questioned whether “she would be able to work with this person.” But with time, and learning the systemic structural violence that this person endured, “I was able to judge him a lot less and see him as a more human person and really see that people are not that simple … I really worked through several, you know, kind of prejudices and that was a big one.” She notes how there were a couple peers “who had similar convictions and you have to, just as the project, you know, takes people in where they’re at and with all sorts of histories, you know – not having those histories
define [and] convict the person forever.” Thus, peer proximity to others peers’ difference produced some peers’ subjectivities as more compassionate, just as it does for dominant subjects.

Peers also spoke about being surprised by how what is often devalued difference was valued in some moments. One peer, speaking on her first encounter with a peer-only group meeting reflected:

I was wondering how people would accept me as a trans woman or two-spirited person and at the end of the day we were going for a tour and I was told that I was honoured in this area. And you could have knocked me over with a feather because here I was feeling very different than everyone else …always wondered how I’m going to fit into a new setting, a new workplace, a new peer group. And being different I find that can sometimes cause a great deal of stress and disadvantage. So this was really remarkable to be told that I honoured the group with my presence and that was something that I’m remembering years later and I’ve got to say I wish there were more spaces like that.

However, assuming that under the banner of peer unity that discrimination occurred less is inaccurate. Encounters within the wider project as well as within peer relations continuously re/generated violence. Lee noted how “even though the project has an anti-oppression framework, I don’t see it as diverse. I really don’t see that there’s diverse thinking. There’s no diverse representation at the table, only from [a select few]. Everything else is not very diverse. And it shows. And it shows just in conversation. It shows just being uncomfortable.” Much of the work that I and other peers did was to manage other peers’ discrimination. Many times I had to confront, offer conflict resolution, and/or remove people from participating because of sexist, racist, ableist and homophobic actions. Peers were brought in and expected to manage other peers’ discrimination. Solutions were offered through teaching and learning, including diversity training. Moments of aggression occurred often between us. Some on the project worked hard to actively recruit a diversity of peers, but could not sustain their participation because of the discrimination they encountered in intra-peer groups. Jackson remembers having “four women of
colour fill peer roles, and how three of them left within the first three weeks. And I am thinking to myself, ‘oh my fucking god.’” Discrimination within our ‘unified peer group’ is as rampant as in the general society.

In confronting difference within notions of peer universality, May spoke at length about the historical commonalities of the population management of Indigenous and disabled people through spatial segregation: “First Nations people were regulated to reserve life and those of us who were not on reserve were disenfranchised. … It came from that old British and French philosophy and thinking, and from that place it’s all about segregation, that place is all about institutionalizing, and that place is all about colonizing, and that place is all about forcing people out of being distinct and into [becoming] some strangely defined version of proper.” Having herself experienced being institutionalized in psychiatric facilities over 20 times, May is able to reflect on how strategies of spatial segregation for both Aboriginal and mad bodies alike work to contain difference. She speaks of connecting with psychiatric survivors groups as having helped in her “pathway to healing,” yet at the same time “you’re amongst all these psychiatric survivors and then you realize, ‘I’m really still around a whole lot of white people,’ and as much as they’ve embraced me and as much as they showed empathy to me there’s still a big gap. There’s a gap in connection here somewhere and then I realized that the gap existed in the fact that I was First Nation and they were not First Nations and it was okay for me to be part of their group as long as I pretended conveniently that I wasn’t First Nations.”

May spoke of connecting with the psychiatric survivor movement but not being “allowed to speak about my First Nations path in that group.” On the other hand, as she started getting involved in her First Nations community, and “getting my name, my clan, my colours, identified as part of my identity and healing pathway,” in order to connect with her First Nation’s
community she had to keep her mental health history and activism “secret, and segregate out my work as a mental health worker and this involvement I had as an advocate … So I always had to deny one side or the other… and the bouncing back and forth and having to be secret about one part of my life and another part of my life, it really struck me as strange.”

She spoke of making connections between Indigenous and psychiatric survivor experiences: “in my First Nations circle listening to women my age or a little bit older talking about the residential schools, talking about their pain, talking about their hurt.” And also “stories that I would hear when I was around all these non-First Nations people talking about the mental health system, talking about their pain, talking about their hurt.” Yet for May, differences in systems of oppression cannot be ignored. She poignantly points to how much consumer/survivor activism is predicated on Western approaches to madness, and white-dominated in composition. She notes how you “wouldn’t hear a First Nations person talking about wanting, at least in my experience, wanting to be involved in a psychiatric survivors group. They didn’t identify their mental health experiences in the same way as these people who are involved in the psychiatric survivors’ movement. We had our own way of looking at and framing and coping with the impacts of our experiences.” While she laments the fact that “never the twain shall meet,” ultimately, May decided to prioritize her First Nation identity, and “I left the psychiatric survivors group and then I integrated myself more into my First Nations world.”

In order to construct notions of sameness across the peer body, the differences that fracture us must be evicted from discourse. Peers often refuse to reckon with difference because to do so would require examining relations of privilege and penalty. In other words, ‘people with lived experience’ is a category that must discourage interrogation of how systems of oppression operate, and land on the ‘peer body’ differently. To assert peer unity, difference is not only
subsumed, but also understood as ‘diversity’ rather than as the systemic and structural ways oppression is organized. This complexity of presenting sameness across difference is impossible, and creates an unsettling narrative that fractures peer representational authority. This incongruence is well summed up by Veronica, who, in reflecting on her relationship with other peers commented on how peers “were from different places and even [had] different religions, different ways of working things and different from me, but still the same. … You know that they went through the same experience, or almost the same. Do you know what I mean? Nobody’s got the same story.”

5.6.2 The Fixity and Transience of Peer Identity

Being peer is described and encountered as both a fixed and transitory state of being. Many peers spoke of their peer subject positions as transient, strategic essentialisms that they assert at times when it was judged useful, and disregarded at other times. Some peers spoke of the ability to ‘pass as normal’ in employment situations, while others felt that they could not, or would not: as Sally reflects on passing, “I think it wouldn’t be good for my, for me psychologically to do that … it’s a big part of your identity.” But many others hadn’t internalized and solidified their peer identity as central to their selfhoods, and spoke of the willful ability to not identify as peers. Anne recounted how she has “chosen not to identify myself as a peer on several occasions” even when working in a peer position because “it gets way too frustrating and I think maybe I just need to go back and find some other job and disappear again and not even be involved.” Paul notes how he is able to leave his peer identity behind when he leaves work: “when I leave here, I no longer have the tag. I try in my life to just, I have the chance to live a normal life.”

Peers spoke of the transitory nature of adopting and disregarding peer identity primarily in relation to work positions. The peer involvement imperative has produced powerful motivations
for proliferating peer identity as a tangible asset, and May notes of being “very well aware of the fact that there’s a lot of money right now out there for peer projects.” Peer identity here is clearly understood as operating advantageously to allow entry into peer employment positions, but also as something that could hinder future work opportunities outside of peer roles. Lee speaks of how “I definitely would have to gear my resume differently if I was going back to the corporate world.” She feels that she would be discriminated against if she asserted her peer identity when applying for non-peer roles, and it wouldn’t matter “how many tasks or duties I was responsible for. It’s just that I’m somebody with experience. And that’s the first thing that would stick out in my resume.” Rachel also spoke about modifying her resume to highlight or downplay her peer roles depending on if it would help or hinder her getting a job: “I take things off and put things on as I see fit. I change things as I see fit. I don’t have any problems with that.”

Lee spoke about how ‘being a peer’ doesn’t usually saturate her everyday subjectivity, but that within the context of working for the At Home/Chez Soi project, “I was really, really thinking about it.” She spoke of thinking about her mental health more because it was contrasted so acutely by working amongst and differentiated against professionals, “because it’s almost a comparison with the professional. So I do think about it more in terms of my anxiety, getting things ready to say, making sure that I can say them at the table. I think about when I don’t get email responses, and what that’s about,” wondering if slow or no response is due to the fact that she is a peer.

Debbie reflected on how peer was the only entry point that she had to access professional circles. She found that there was fixity to her peer identity that she could not always control. Despite a university degree and various professional skills, she recounted a time that she applied for a role that was not peer-specific, but when she got to the table, realized that she had been granted into
the assemblage to represent as a peer. Drawing on the analogy of the purple hat to represent ‘peer perspectives,’ she noted that “I didn’t say that I want to wear the purple hat. They decided I was wearing … they decided I fit into the purple hat.” Such encounters show the fixity of peer identity even when some peers understand it to be a fluid and moveable one.

As Jackson notes, ‘peer’ is limiting by its very definition: and “suggests that your own identity is a made person,” fixed in your own experiences and solidified through identity. Rachel reflected that while she is able to transcend her own self-perceptions of peer subjectivity, that others graph such identity onto the peer body, making it impossible to shake. She notes how “in addition to my wondering whether I am authentic enough, whether I am crazy enough to be a peer,” yet “wanting to show people that yes you can be really intelligent and well educated and also have lived experiences of mental health issues or ongoing mental health issues” the minute you are authorized as peer, your authority to be anything else ceases. She notes how, through this process of becoming peer:

> everybody just looks at you different. They expect different things of you. They don’t expect you to speak in a certain way, they don’t expect you to have a level of knowledge that you have, and they don’t want to listen to you – everybody will filter. You know I felt this way when I would go sit in meetings with the researchers and they would filter everything that I was saying through the fact that I was crazy. And who necessarily wants to be identified with that? So there are some opportunities for challenging things, there are some opportunities for surprising people I guess, in a way. But there’s also, it’s like they just stopped listening as soon as you open your mouth.

Peers understand that we are caught in a web that can pin us to peer identity. May spoke critically about the ways in which both the psy disciplines and peers have solidified what can sometimes be a transitory experience into a fixed category of difference. She notes how peer identity is yet another component that works to retrench notions of mental difference: “Honestly, like we’ve legislated it, we’ve medicated it, we’ve created entire fields of professional practice around it, we’ve got psychiatrists and psychologists and people who create medications that
psychiatrists can then give. There’s an entire world built on keeping people’s life and identities regulated to something … [and] whatever it is that you are, you’re not a mental illness.” May spoke in complicated ways of understanding the need to assert peer identity and advocate for peer roles, yet on a personal level slowly stepped away from peer work. May spoke of peer identity as something that is willfully adopted, unlike race, and noted how she’s “just moved beyond it” and “on a very personal level I am really sick and tired of having everything in my life revert and referred back to a period of about five years of my early 20s. And I’m guessing I’m not the only one who’s going to get sick and tired of having everything revolve around” times of crisis.

She notes how unsettling notions of peer identity as fixed and natural is hard to do, as it risks negating or denigrating the power of peer, and that what she is saying “might be uncomfortable for others, because telling them that I don’t think that they need to have a peer identity for the rest of their lives may not be what they’re ready to hear yet. And because they want to invest so much of their time, and themselves, their spirit, their soul and heart have been poured into making this component of the At Home/Chez Soi project a success, I don’t want to disrespect them. But I don’t feel that way anymore. I don’t think that way anymore and I’ve evolved in how I see things needing to happen.” May understands the possibilities that peer identity can produce through peer inclusion, yet has also come to understand the conditions and limits of participation: “For the last 12 years I’ve walked with this movement and I’ve seen and contributed in small ways to its evolution to the point now where the things that I was really wanting to see 12 years ago have come to fruition. And I didn’t realize it [then] but as soon as I saw them I realized and thought to myself, ‘yeah, this isn’t enough.’ There has to be more and I’m no longer the right person to be part of this kind of work anymore. Because my eyes have
grown and changed.” Here, May questions the limits of what drawing on experience can produce in order to make social change.

5.6.3 Reifying Mental Difference

A key question to consider is what is the performativity of peer subject positions? Throughout the interviews, peers spoke of doing peer work in order to challenge notions of the chronically homeless mentally ill as unsalvageable subjects. One of the primary purposes of working under a peer identity is the hope that it would unsettle the stereotype of the mentally ill as an unworkable subject. Peer work roles are supposed to change the minds of professionals by having us embody capacities that we are unexpected to hold. Yet, as I have shown, when we perform such capabilities as peer informants, it simultaneously works to delegitimize our authenticity as the truly ‘homeless mentally ill.’ When we function as normal, it is because we are not actually authentically part of the abject body. So when we succeed at being professional enough to incorporate into the assemblage, it becomes because we are no longer a part of what we have been brought in to represent.

Another key trouble that adopting a peer identity risks is the reification of mental illness as a true essence that exists in the corporeality of those that embody peer identity. While adopting a peer identity can try to subvert the archetype figures of ‘the mentally ill,’ it can also offer proof that we occur as a troubled population that requires medical intervention and remedy. Thus, peer performance risks performativity that can work to solidify the ongoing work of the mental health industrial-complex. I contend that regardless of how individuals self-identify, conceptualize or articulate explanations of their madness, be it through discourses of trauma, discrimination, psycho-social, social determinants of health, or purely biological default, the peer body as a unity works to reify dominant notions of mental illness within the context of mental health.
governances. In this way, we reproduce the idea of a troubled population that requires intervention. And as peer workers, we have become key players in sustaining ongoing neoliberal strategies of governance.

I felt this happening during the course of my work. I came to realize that regardless of my constant internal work of processing the fields of power operating in and around me - my conceptualization, approach, and critique of the psy disciplines, putting critical theory to use, my resistance to the discourses that constitute power - in the end, my body as a seat at the table was still a mentally ill body. Sometimes, I articulated my interpretations at the table to offer counterhegemonic views – and sometimes when voiced, this language was taken up as knowledge proper. Other times, my resistant language and embodiment was simply interpreted as proof of my madness, or worse, proof of my mental illness. Often, all of this was happening simultaneously, and impossible to quantify. In the end, as I negotiated myself within the assemblage, watched as other peers emerged, congregated, and appeared as a substantive body within various worksites, I certainly saw how the peer body can work to disrupt conventional mental health regimes of ruling. But ultimately, that our very presence as difference reifies dominant understanding of us as ‘mental illness’ realized. This has productive value, for as Ahmed notes, notions of ‘“otherness’ and ‘difference’ function to sustain rather than problematise the imaginary boundaries between different nations, or groups of people” (Ahmed, 2000, p. 116). Peer work is premised on dominant notions of difference based on experiences of mental illness. In this way, by harnessing a peer identity mental illness can be solidified as a truth coming into being by the presence of peers as subjects. We embody mental illness, and this works to make real discourses of mental illness as a truth. Hence, the politics of resistance and representation in the mental health field is a risky negotiation that can work to solidify just as it works to transgress.
How does the process of occupying peer identity impact those that are embodying such difference? How does it reify and undermine our own understandings of ourselves as troubled subjects? Ken reflects on what this can effect in relation to peers’ subjectivity: “The problem is [peers] may be internalizing it more, right? Because if you identify as having a mental illness, then you know there’s a part of you that is sick, right? And if there are people around you that also have that analysis and feed into it, that can be really detrimental to people. For me, the idea of mental illness is detrimental once used from the outside, used by society, but it’s also detrimental to the person thinking about themselves [that way], for a lot of reasons.”

When asked whether her experiences with psychiatry had become a more prominent part of her identity now that she was working in peer positions, Anne said “Yeah, and in not necessarily a good way. I feel like I struggle now more with identity issues. So it’s become a greater part of my identity and in some ways I think, ‘is this really where I should be going’ because now I’m thinking about it all the time.” She went on to reflect on how she is now limited to “identifying myself by my illness which is counter to so many things … it’s not even talking about the real issues, you know?” She attributes working in peer positions to making her feel a “little wonky” and “I never know how to describe my illness or how to describe why I’m here.”

Heyoka reflected that “I much more identified myself with my mental health issues” while doing peer work. Bob spoke of how occupying a peer identity in his work position became all consuming:

I think about it like a lot more. That is like too much to handle. Like it’s just taken up so much of my time and it’s super-stressful. Like it doesn’t go away, right? It’s not like you can come home and just like turn it off. You come home and think about it more. So I don’t know if you’d call it an obsession but it’s just all the time, 24/7 almost. Except for sleeping. And it’s all that I kinda talked about with people. It was the center of everything I did – all the conversations I would have. And I could see my family, like, ‘Oh, here we go again.
Bob went on to reflect on how both the work and “always having to defend my position” as a peer in the workplace “definitely contributed to a slow and steady decline in my mental health. And my addiction as well. Like I started out being totally clean and fairly confident and feeling healthy and then just bit by bit, it kinda ate away at that.” In this way, Bob spoke about working with a peer identity in a peer role as having detrimental effects on his wellbeing.

Most people emerge as ‘peers’ through professional encounters. They are made to know themselves as mad/mentally ill through encounters with the psy disciplines, and are also harnessed into peer roles through professional mental health and social service systems. But there are also those who have actively worked to resist defining their selves through direct encounters with professionals. Heyoka recounts how she has worked to avoid professional diagnosis, and how that in part has to do with her awareness of racial and cultural bias within the system.

I haven’t actually had experience with the mental health system. I’m probably representative of people who don’t seek mental health care in the system. And so I’ve never been formally diagnosed, I’ve never been medicated. I’m also a peer, though, in that I’ve also been homeless. And I do identify that I have mental health issues, I just choose to deal with those on my own. I don’t want to be medicated. And I’m not even sure that I want a diagnosis on my record. So that’s where I’m at with that. I’m very open about talking about it to real people that I meet, but I don’t know if I want it connected with the paperwork that the government sees, if that makes any sense. And it seems like the types of doctors that I’ve always had access to treat people with my background as though we’re perhaps medication seeking or something, or you know? And so I’ve never felt comfortable in talking about being depressed. And I also didn’t think a pill would solve my depression, because I know my depression – well it’s partly situational. It’s partly due to my history. I mean I can trace where it’s due to. And so I did reading about depression. I learned about symptoms. I identified what parts of myself correlated with those and I was able to develop my coping strategies.

In this way, there are those amongst us who are strategically avoiding official dominant encounters with the psy disciplines as a form of self-preservation. Heyoka’s motivation is
contrary to popular discourse of people resisting seeking treatment because of ‘the stigma of mental illness,’ but rather identifying the oppressive ways in which the system is organized as motivation for making sense of the self outside of official encounters.

Others spoke of harnessing a peer identity as having little negative impact on their subjectivity, but still found it challenging. Clair reflects that she had long worked in the mental health field as a peer and that within the context of the work she did with At Home/Chez Soi “it became a little bit more important but it was already important in my life … but not my experience of homelessness though. The project brought that to the fore. I had never used that in any situation or you know thought about identifying that was necessarily as a person who was homeless, even though I have been … Although it was a little challenging having to identify that way with people around me outside of the project. You know, saying that I’m a peer on the project, because I had been homeless kind of outed me to people that I wouldn’t necessarily have outed myself to. So I had to identify that way in public.”

Clair also spoke about the outcomes of her time as a peer on the project as having positive impacts on self-concept and relations with others. She noted how “my family had known me for a long time as somebody who was just a train wreck” and through the work “they were able to see that I was doing something productive and worthwhile. And you know that was a positive thing and I was also able to educate them about a lot of stuff.” Clair notes how her sense of self changed through being incorporated within the project, as adapting a peer identity changed her from being a subject unlikely to work because of disability towards someone with labour value:

To speak on a personal level – it was good for my self-esteem. When I went on disability I was given a vocational assessment and they told me that the most I could hope for was [that] I could maybe be a cashier. And I just felt really worthless and discarded and, you know, hopeless. And I didn’t know what contributions I could make to society. You know I had all this volunteer work to make myself feel better but I still felt like it was not
that important. So to be able to do the work that I did with the project, it really proved to myself that I was capable of doing meaningful work and challenging work, and that was very rewarding.

In this way, harnessing peer identity and doing peer work allows some of us to reconstitute ourselves as viable labour, and given that employment and productivity are central ways in which subjects are constituted as citizens, for some, peer work allowed for the reconceptualization of selves towards fuller citizenship.

5.7 Conclusion

This chapter unsettles notions of ‘the peer’ as a naturalized identity derived from experience, but rather shows how discourses, interpellation, and subjects together produce the possibilities of becoming peer. I show how the peer subject has become possible through converging progressive discourses of community integration, recovery, and social movement activism in combination with the emerging marketization of health and social service industries within the context of biopolitical neoliberalism. It is within this history of the present that the peer subject emerges, as a figure that has transformed attributes of distress into a viable economic possibility through peer participation. I show how peer identity is a strategic essentialism that is harnessed through interpellation and put to use to access peer work positions within mental health and social system governances.

I draw on postcolonial theory that queries the representational authority of those that are brought in to speak as Third World others within Western governances, and how through such a process, transform as subjects into someone else – the native informant. I apply such theory to the peer subject, and show how in being brought in to represent the ‘chronically homeless mentally ill,’ subjects can no longer speak as those they represent, but rather become peer informants. Through
such process, the peer as a subject becomes a contested site of embodiment, whereby peers must grapple with their authenticity and representational authority to speak and act on behalf of those they have been brought in to represent. Through interview and ethnographic data, I show that the peer informant must negotiate their own and others perceptions of what constitutes the authentic peer. I explore how representing peer is an intricate process, whereby subjects must bridge both respectable and degenerate attributes in order to pass as peer. This requires complicated performance, and I show how peers manage their identities in ways that both signify professional and denigrated attributes.

I then explore how peers contend with both building notions of a universal peer body in order to authorize our representational power, yet simultaneously recognize differences amongst us, which works to delegitimize our representational power. Notably, notions of difference are often taken up within frameworks of ‘variety’ or spice, rather than as difference through which oppression is organized. I also show how peers are made through proximity with others: in this case study, peers specifically come to know who they are and are not in relation to professionals, the ‘chronically homeless mentally ill’ participants, and fellow peers. I then explore how peer identity is both a fixed and transient identity: one that can be strategically adopted and disregarded when deemed suitable, yet at the same time, how for some, there is a fixity to peer identity that operates beyond their control. I end by querying the performativity of peer identity, and mark the potential risk that harnessing a peer identity produces: the reification of mental illness as truth. In this way, peers reproduce the conclusion that the bodies and populations that we represent require governance.

In this chapter I’ve shown the possibilities, constraints, and conditions of becoming a peer subject. This contributes to critical inquiry into the politics of resistance and representation
specifically within realms of inclusionary practices in the mental health and social service sectors. Importantly, this chapter maps how peer identity and peer work marks a departure from social movement activism. Subjects come to recognize themselves as peers largely through individual experiences of distress, and not through collective social movement activism. Peer identity works within individualizing liberal frameworks which prioritize our personal experiences, rather than critical political orientations focused on systems change. In the following chapters, I chart how it is our individual experiences of distress/homelessness that is deemed as ‘useful knowledge’ which, through incorporation, can help in the governance of the ‘chronically homeless mentally ill.’ When we make attempts to resist being pinned to personal experience, but rather undertake work which refocuses on challenging mental health regimes of practices and truth, we run into trouble. This elucidates the limits of relying on identity and experiential claims to undertake social justice change, because our worth as informants becomes constricted to personal experiences, and is not conceived as analytic knowledge that should be used to ‘study up’ how systems of power together work to subjugate ‘the chronically homeless mentally ill.’ In the following chapter, I explore what is generated through peer storytelling, as one of the fundamental ways in which we narrate our authenticity and authority in the ongoing process of becoming peer subjects.
Chapter 5
Peer Storytelling: The Performance and Consumption of Recovery Narratives

How do you inscribe difference without bursting into a series of euphoric narcissistic accounts of yourself and your own kind? Without indulging in a marketable romanticism or in a naïve whining about your condition? In other words, how do you forget without annihilating? Between the thin chasms of navel-gazing and navel-erasing, the ground is narrow and slippery. Trinh T. Minh-ha, 1989, p. 28

6.1 Introduction

In the last chapter, I showed how developing peer identity is a complex process which requires consistent negotiation and maintenance to embody. In this way, I denaturalized peer identity as innate to those who hold particular experiences, and rather showed how peer identity is something that is made possible to claim through particular contexts and specific activities. In particular, I showed how peer identity is often harnessed in order to attain work positions within social service and community research interventions. By harnessing peer identity, I and those that I interviewed had to manage a performance that at once presented us as degenerate enough to represent the ‘homeless mentally ill’, yet at the same time respectable enough to work as ‘professionals.’

Storytelling is central to this process of making ourselves into peer subjects. We make ourselves knowable as peers through the stories that we weave of our past, present, and possible future. Crucially, storytelling is also the central work that we are asked to do as peer workers. When working in peer roles, we are expected to tell personal stories of our own histories of homelessness/distress in a variety of contexts: we are to draw on these stories to relate to project participants through peer support; we share these stories with professionals to help intervene on current mental health practices; and we are consistently asked to narrate our stories at
organizational events. I argue that our stories are key commodities to be used to authorize our power in the workplace. In this chapter, I explore the contexts in which storytelling is expected, required, and disallowed, the rules governing how peer stories can be told, and when and how they are celebrated, ignored, or disputed.

In this chapter on peer storytelling, it is important to forefront that this is not a story of devaluing peer narratives that draw on personal experience. Rather, I am exploring how such stories, in their amalgamation, work to build both contesting and dominant narratives of who we are as subjects, communities, and nations. As Razack notes, narratives are different from the telling of personal stories: narratives assemble stories in ways that work to produce metanarratives about something else, which means “separating the experience of individuals from the way in which their stories are assembled for our consumption” (Razack, 2004, p. 18). It is not how we make sense of our individual experiences through storytelling that is under scrutiny here, but rather, how our peer narratives work to produce truths about us that define us as problems to be solved. Current understandings of madness as mental illness shape the ways in which we are able to tell peer stories, how they are heard and interpreted, as well as how they are harnessed as narratives. Here, I deconstruct the process of individuals telling their intimate stories of homelessness and distress as simply ‘personal experience,’ and look towards how such stories, under accumulation, contribute to metanarratives of us in the social realm. I explore how the rules that govern peer storytelling work to sustain current dominant understandings of madness. As I show, peers are encouraged, rewarded, and become experts at telling ‘recovery narratives:’ stories that work to build larger narratives of us as redeemable subjects.

I start with auto-ethnographic and ethnographic data that both draws on and unsettles a personal story that I have shared in my peer role as a consumer research consultant for the At Home/Chez
Soi project. I use my story as an entry point to explore both the possibilities and dilemmas of using subjugated knowledge to intervene on metanarratives of the homeless mentally ill figure, drawing on theoretical work that has queried both the constraints of speaking and of hearing. I use the story of telling my story to elucidate, in particular, the trouble of speaking multiple selves through the opening of a peer identity. I follow by exploring critical anti-racist scholarship that has outlined the possibilities, limits, conditions, and performativity of storytelling for social justice ends, and then specifically that of emerging scholarship on the problems that peer narratives pose.

I then draw on interview data to explore how those working in peer positions reflected on the process of sharing their stories in various work settings. I show how peers speak of the purpose and possibilities of storytelling; the act of storytelling as central to peer work; who gets to tell such stories, and how they are self/governed; tactics peer use to control how their stories are put to use; and how storytelling is understood as risky business. I end the chapter by showing the productive value of storytelling for organizational and national interests. I show how stories of the descent into and recovery from mental illness and madness work to create exalted subjects (Thobani, 2007), ‘storytelling superstars’ that use narratives to consolidate organizational, system, and national interests. I end by advancing that our individual stories are used to generate public debate: our stories bring a ‘human face’ to a denigrated abstract and abject body, a device added to prevailing regimes of truth about madness in an attempt to make us as a population recognizable as human. This tactic allows a general public to explore both who the ‘chronically homeless mentally ill’ are, as well as how we relate to such a population as a nation. How we deal with abject bodies as a nation tells a hegemonic story of who we are as a white civil society: of who we are as Canadians by how we deal with the trouble that the homeless mentally ill pose to us as an advanced liberal democratic nation.
6.2 Performing the Revolting Subject

The first high-profile public event that I was asked to contribute to in my role as a consumer research consultant was to share my personal narrative, as part of an opening plenary panel for the MHCC’s first major conference, held in Vancouver November 29th – December 1st 2009. Alongside an MHCC representative and a researcher, I was asked to share my lived experience of accessing both homeless and mental health services. I have such stories to tell. The event was a seminal moment for the MHCC, the conference titled “Into the Light: transforming mental health in Canada.” The “Into the Light” reference stems from the insistence from the MHCC, as is their tagline, to bring mental illness “out of the shadows at last, and into the light.” It alludes to the quest to bring ‘mental illness’ into the light, to make our collective haunting of madness knowable, to illuminate danger and risk, to bring out those from the shadows that hide there, and to learn, examine, co-constitute, and effectively master difference. One cannot fix if the broken remains unknown.

As I contended in the previous chapter, the ‘homeless mentally ill’ subject is a shadow figure that haunts the safety of our communities, families, and selves. Ahmed argues how respectable civil subjects who know how to avoid the dangers of public spaces are constructed as street wise: “Becoming street wise defines the subject in terms of the collective: the wise subject has collective knowledge about what is ‘safe, harmless, trustworthy’ and what is ‘bad, dangerous and hostile’ that gives the subject the ability to move safely in a world of strangers and dangers” (Ahmed, 2000, p. 34). In order to best inform the ‘street wise’ civil subjects on the dangers of the stranger Others, the (usually recovered) homeless mentally ill – those that are understood as those that pose risk – are asked to share our knowledge so that the street wise can be armed with best practices in order to prevent and intervene on us. ‘The homeless mentally ill’ also remind us of the violent practices that we rely on in order to ensure our safety; our ongoing legacy of how
systems depend on exclusion and repulsion in the name of a nation fixated on purity. As Kawash notes, “if the violence that produces the homeless body is justified in the name of public security, than any attempt to loosen this relation must expose the public, simultaneously, to its constitutive violence and to the promised security as fundamentally insecure” (Kawash, 1998, p. 337). This necessity of securing order through violence generates a collective national unease which risks evoking historical remembrance of those who have been killed, mutilated, incarcerated, sterilized, left for slow death, and legally cast out of civil society because of difference. And the reminder still of an ongoing fear that anyone can, at any given moment, give way to madness, a flexible and mobile oppression.

My body is so flexible. It has produced difference and difficulty in innovative ways over the course of forty years. I produce intolerances and abilities that shift: I have to stay on top of my own shape-shifting. One struggle that has been ongoing has been pain: in earlier life in my lung, making it difficult for me to breathe. Breath was pain, and forced me to be very quiet and still. This passed, but my digestion soon became disruptive and angry, and much of life is spent preoccupied with managing and looking to cure my stomach. When I started my work with the MHCC, this got much worse. I lost control of it, and inconvenient, often debilitating episodes of expulsions, of both vomit and diarrhea simultaneously, took hold and stayed with me throughout the length of the project. It preoccupied my every move: I was always in a state of either trying to prevent, manage, or ‘work with’ while all of this abject worked against me. These ‘expulsions’ were read as psycho and social and both: the psycho as anxiety, leading doctors colleagues and friends to point to better stress-management, behaviour modifications through CBT, ‘pam prescriptions. The social as food eliminations, reduced travel obligations, and resulted in me awkwardly excusing myself from collegial dinners. It was the first time that I was surrounded by the richness of free food, and my body angrily refused to contain it. We settled on IBS, a
psychosocial diagnosis: it is both my insides and the outside’s fault. It becomes a constant revolting rhythm to be working against.

I remember trying to manage my body as I got up on stage, after the Coast Salish territory welcome to country ceremony, in front of a crowd of over 500, many of whom were wearing official state uniforms. I felt my stomach turn and my breath shorten.

After the plenary – after the standing ovation and the hugs from ministers and senators – the following days of the conference are a painful flurry of encounters. I am the stranger revealed. The hordes of people who come at me entitled to speak to me of me, and infer on me, are a mass of unknowns. I begin to try to make sense of them just as they are making sense of me. I categorize them by what they say to me: I imagine those that complement my oratory and writing skills, the ‘you are very articulate’ and ‘I liked that you grounded the problems as a social justice issue’ to be a particular kind of academic, peer, or perhaps artist. Those who use words like ‘cry,’ ‘brave,’ ‘strong’ might be anti-oppressive social workers, and perhaps feminists. And then there are these: ‘I never would have known by looking at you.’ The man who identifies himself as a psychiatrist who informs me he could tell me by the way that I dissociated while speaking, by staring up at the ceiling. To the outright question of what my diagnosis is. What is your diagnosis, anyways? I line these people up as clinicians, psy discipline practitioners, scientists. When hearing them, I need to categorize and make sense of their ontologies through guessing their subject positions, to make sense of these masses, just as they have used my language to make sense of me, and themselves. These face-to-face encounters remind me that “in daily meetings with others, subjects are perpetually reconstituted: the work of identity formation is never over, but can be understood as the sliding across of subjects in their meetings with others” (Ahmed, 2000, p. 7). These encounters also affirm that the conditions under which I am heard far
outweigh anything that I can say to sway understandings of my peer narrative as anything other
than the personal tragedy of weakness, poverty, and mental illness.

Stemming from that storytelling, I am approached at the same event to do more of it. I am not
usually a hot commodity, and my resistance is felt: as a PhD student used to paying for my
opportunity to speak at conferences, suddenly, I am being paid to speak my personal narrative.
Generated from that one talk, I accept to speak at a few others. My lived experience has
generated a commodity of plenary presentations. I learn, uncomfortably, that bringing my abject
out pays.

The first of this storytelling circuit, Summer through Fall 2010, took place at a Centre that does
critical inquiry into practices of gender, mental health and social inequities. It is a venue that I
trust, and I ask if I can both present my narrative, as well as query what it produces, which was
met with full support. What follows is the narrative that I presented.

6.3 Consuming Consumer Narratives: A Struggle Over How to Eat and How to be Eaten

I know a thing or two about the benefits and drawbacks of taking up the subject position of
“person with lived experience,” as it is a seat in which I constantly sit in for my job. Sometimes
that seat feels like a throne, sometimes it numbs my ass, and often it drives me into bed. Today,
standing, I’ve been asked here to share a talk that I gave six months ago at the opening plenary
of the Mental Health Commission’s “Into the Light” conference. It is a talk that shares my
experiences of homelessness and as someone who has accessed mental health services. This talk
is not, however, a pure reiteration, as I have added further to it to express some theoretical
considerations on the limits of self-representation, concerns that I am struggling with in my
doctoral work. I know that this “thinking through” will be appreciated at a workshop that is
titled “Critical Inquiries,” from a Center for the Study of Gender, Social Inequities and Mental Health. Or, to rephrase, and to point to the crux of the matter, I can HOPE that this reflection will be HEARD in ways that gently negotiate the delicacies of me telling, and you listening. I’ve titled the talk “Consuming Consumer Narratives: A struggle over how to eat and how to be eaten.”

So, here, for you, is the talk that I gave six months ago.

As mentioned, I am here to speak of my experiences of being a street kid, and of being psychiatrically diagnosed. People like me are often asked to tell our stories, for many good reasons, which include imparting experiential knowledge that would be inaccessible without us. Having said that, I am also always a bit wary about “telling a story” to people who might understand what I say along an individualist framework. When we listen to stories, we often want to frame them as isolated personal issues that arc along a progressive timeframe. We start with normalcy, interrupt with individual tragedy, mention hardships, mark interventions, until we get to a place of heroic overcoming and recovery. These story frameworks add cohesion to lives that are always far more complex. These are the plotlines that fairy tales follow. This is not the storyline that I can put forward to you today. There was no evil witch that led to my downfall, no seven dwarves that took me in and nursed me back to wellness. And certainly no prince charming who was waiting in the sidelines, patiently, helping me to overcome.

Rather, as I share a piece of my story with you here today, I want you, as partners in this narrative, to think about how this story must be understood as one that transcends a simple victims vs villains framework. That this is not an individual story about my overcoming, but rather must be understood as a tale where bodies, as Disability Studies scholar Catherine Frazee puts it – “collide with the larger forces of power and structure and governing relations
that constitute the stage upon which the characters, including ourselves, perform our parts”(2009).

If life is stage, and this is theatre, then I ask that this story not be understood as mine only. Any actor will tell you that the biggest player in any production is the audience, and audience response. And with an audience filled with social workers, housing providers, mental health workers, psychiatric professionals, academics, family members and my fellow people with lived experiences – I ask you to think about yourselves through this narrative, how you are activated by my story, where you fit, who you become, how you are implicated, and how we can lend to this need to complicate “my story” as “ours” – something that we are all involved in, and that we share.

The picture I chose to frame this talk is one of my brother Michael and I. I chose this picture because we are both in movement, in consort, he a little ahead of me, as he always was, as my only and elder sibling. At the time that this picture was taken, I was 17 years old, living on welfare, and marginally more secure as I had been in years previous, which had me living on the streets and couch surfing my way through my early teens. My brother, almost 20, had recently been released after a 3 year incarceration in a forensic unit of a juvenile prison. He was living in a half-way house when this picture was taken. Struggling with rules, with fear, with conditions and confines, we both were. Hungry, angry, and stunned by marginality, diagnoses and social and mental health regulations. And trying to figure out how to breathe through it all.

Michael was what is understood as hard to house. Workers tried, we all tried, to get him to a place where he could stay. His housing ranged from forced institutionalizations to half-way houses to rooming houses to shelters to subsidized co-ops and back again. He was in and out, up and down, on and off, back and forth. He was usually being kicked out, most times abandoned by
services once he misbehaved. Unlike the Housing First model that the At Home/Chez Soi project is studying, where service supports continue to work with you to find another suitable housing unit when one is lost, Michael had no such help.

Michael died at the age of 21, while living in a transitional house – making that yet again familiar transition from institution to waiting for permanent housing. When he died, the conditions in which he was housed were beyond substandard. I ask you to draw on your own imaginations and picture your worse-case living scenario – coupled with people constantly monitoring your behaviour, witnessing and assessing your every tick, and the stifling heat of abject poverty. So stifling and squeezed was his room that he had to tilt his bed up against the wall in order to be able to open his closet door. Space matters. It was little surprise to me that it was while in this room that he decided to stop trying to breathe. It nearly took my breath away as well.

My housing story is different from Michael’s. While he spent his teenage years locked up, I spent mine hiding from confines – on the streets and then in mostly rooming houses. Again, I leave you to imagine what being a street kid was like, for me. And of course, here, to consider how my gender, whiteness and general aesthetic (read young angry doc martin wearing feminist) affected the ways in which I was interpreted and diagnosed by psychiatry. In the early 1990s I lived on monthly welfare cheques that have not increased in amount since then. It is impossible to live on under $600/month, now, in Toronto, and remain both housed and fed. I count myself lucky, because I squeezed in my welfare time just before the Ontario Harris years, living on what was known as student welfare for 4 years, which allowed me to scramble from rooming house to high school to after-school outpatient appointments. Two months after I completed high school, student welfare was cut. Had I been born a few years later than I was, the Harris conservative
provincial chill would have forced me into workfare instead of allowed me an entry point into an education.

I would not be here with you all today.

Space, and social policy, matter.

A few months after my brother died, I landed a one bedroom apartment in a rent subsidized building. I spent a decade – from 20 to 30 – in that modest but well savoured apartment, with my own bathroom, a handyman janitor, and most importantly the dead-bolt locked door whose keys I held. Over that decade I ebbed into periods where privacy, the freedom to be alone, and boundary-building were important → that transition from street life, where you are always seen, always engaging with public life, with stranger-dangers → to getting used to, and relishing, my privacy. I flowed into rest, into books, and eventually into university → with subsidized rent, I was able to live off of student loans and enter the culture shock of U of T. I ebbed into health struggles, which were much easier to familiarize myself and others with under the calm of home. I flowed into love, slowly into life, into things that are so hard to come to fruition when you don’t have your basics down.

I ebbed into grad school, flowed into jobs – and finally, after 10 years of shelter provided by the safety of my subsidized apartment, was ready to let it go. I knew that someone else was desperately waiting for the opportunity that my modest and cheap apartment had given me.

In telling this story, I wanted to make sure that I put Housing First. To show how my brother’s treatment did not – he was over-serviced in many ways, underserved in many others – never given his own place to be unwell, to cover to recover, to uncover, to discover. I fell into a place where I was able to be – well, unwell – how I was. It took a long time for me – to shift my rage,
my sadness, my fear – into articulations that would no longer hurt me. I needed that time, and
my housing helped.

Cut – and end scene.

6.3.1 The Limits of Hearing

While I am extremely cautious of using ‘stories’ as a way of critiquing systemic oppressions, I
have often used personal narrative and political auto-ethnography in an attempt to centre
marginality. It has been a way of expressing what I know in my body, in using subjugated
knowledge as a form of resistance – and this is a writing tool that I have drawn on for many
years, as a way of “thinking in skin” (Brooks, 2008, p. 242). I am also incredibly conscious of
what ‘giving good story’ can do, how it can be used, and how representing a ‘coherent self’ to
an audience can work within sanist frameworks of meaning-making.

As a disability studies scholar, I have been encouraged to speak from and of myself, to speak
from the space of mad knowledge, to use that which can evict me from civil society and turn it
into subjugated knowledge (see Garland-Thomson, 2007). Michel Foucault defined subjugated
knowledges as “a whole set of knowledges that have been disqualified as inadequate to their task
or insufficiently elaborated: naive knowledges located low down on the hierarchy, beneath the
required level of cognition or scientificity” (Foucault, 1980c, p. 82). Thus, Foucault felt that
using voice to “make visible the unseen can also mean a change in level, addressing oneself to a
layer of material which had hitherto had no pertinence for history and which had not been
recognized as having any moral, aesthetic or historical value” (Foucault as cited in Spivak,
1988, p. 285). Drawing on Foucault, I have always been committed to using subjugated
knowledge as a way of disrupting who and what is understood as knowledge proper.
As a methodology, auto-ethnography and other reflexive practices as re-interpreted through postmodern and poststructuralist thinking have worked to redress the legacy that past ethnographic practices within the social sciences have left. Thus, post-modern auto-ethnography and political narratives should articulate how any story is a storied story, one of multiple, and that “postmodern ethnographic text is dislogical rather than monological, partial rather than apparently total” (Ahmed, 2000, p. 63).

Despite my attempts to orient the hearers away from my story as one of monolithic individual tragedy, I know that marking it as collective won’t change the ways in which it is consumed. I worry, as Gayatri Spivak insists, about what the utterance cannot say, as well as how “the intellectual is complicit in the persistent constitution of Other as the Self’s shadow” (Spivak, 1988, p. 280). Standing up here as a stranger, as a consumer, I have already been “produced as a category within knowledge, rather than coming into being in an absence of knowledge” (Ahmed, 2000, p. 55). You know me and yourselves already, we have already be co-constituted, most of us here today fractured through the divides of “user” and “provider.”

Spivak’s question as to whether the subaltern can speak haunts me as I stand before any audience. She asserts that the subaltern does not speak – or rather that a condition of being subaltern is that you are not heard. “In other words, the question becomes not so much, ‘who speaks?’, but ‘who hears’”? (Ahmed, 2000, p. 61) To push this question further towards us today, how is it that I am being heard?

As a mad informant, I offer my consumer narrative up for consumption hoping to be able to control the ways in which it is savoured and swallowed. Knowing, as bell hooks reminds us, that “the commodification of Otherness has been so successful because it is offered as a new delight, more intense, more satisfying than normal ways of doing and feeling” (hooks, 1992, p. 21). That
eating the other involves the process of consumption: “one swallows, digests, farts and shits. One takes in, and lets out. The white consuming subject is invited to eat the other: to take it in, digest it, and shit out the waste” (Ahmed, 2000, p. 117). My story isn’t digested as a critique on the tyranny of sanism as embedded in imperialist white supremacist capitalist heteropatriarchy. Rather, it remains a story of tragedy and recovery, despite my attempts otherwise. The madwoman can speak as the madwoman – but how can she be heard? What are the conditions of my consumption, and the possibilities of hearing?

I sit in this struggle to be heard on my terms, even though when I speak I can feel the articulations drift away from what I mean. Still seduced by the idea of subjugated knowledges, and still committed to Foucault’s claim that it can shift epistemes. I still feel that speaking from a mad auto-ethnographic position can contribute to knowledge production that understands “cultures not as monolithic, pure entities, but as overlapping, as interdependent, in which the patterns of power and domination are never expressed completely, but are accompanied by resistance and subversion, by point and counterpoint, and where contemporaneous events can produce antiphonal responses . . . History is a giant fugue of interweaving themes and voices, of subject and reply” (Symes as cited in Chowdhury, 2007, p. 109). I am most concerned with Spivak’s assertion that “a testimonial ethics is not simply about speaking, but about the conditions of possibility of hearing” (Spivak as cited in Ahmed, 2000, p. 157). How, in these moments of voicing, “can we encounter an Other in such a way, in a better way, that allows for something to give” (Ahmed, 2000, p.154)?

6.3.2 Producing the Recovered Subject

My unsettling questions that linger include: what is being produced in these moments of listening? And further, how can we be heard without being consumed? We all have to eat. How
is sanity regenerated in consumer narratives like the ones that I have just performed? What, and who, is reconstituted in moments like these? Is this just “useless knowledge” for others to take pleasure in (Razack, 2007, p. 389), or is voicing madness making a contribution to subjugated knowledges?

Presenting a consumer narrative to an audience of largely ‘the helping’ professions is a complicated process. We cannot have my madness without the likes of many of you, those that constitute yourselves as sane. Through my storying, I allow for my difference to be made knowable and mastered. Many of you regenerate yourselves again and again as “the authentic knower while [I] remain what is to be known and consumed, and spit out again” (Razack, 2007, p. 379). Through my consumer narrative, an audience of psy professionals continue to be able to reconstitute themselves as rational, compassionate citizens, and through hearing, my story gets “transformed into [their] pleasure, the good feeling that [they] get from contemplating [their] own humanity” (Razack, 2007, p. 382).

Further, I contend that my particular narrative – from street kid to PhD student – is understood within the more gentle but still medical model framework of the Recovery Model, a framework that argues that people should strive to eradicate and fully recover from their mental illness (Amering & Schmolke, 2007). In the days following my presentation 6 months ago, I was referred to countless times as “recovered,” or on the road to recovery. I was blanketed by their desire to see me as cured. They needed to understand me as recovered: firstly, because I could no longer be mad and at the same time be comprehensible to them, or to a PhD program, or to research. And secondly, they needed to understand me as recoverable because it constitutes them as human, their helping work as successful, and their psy disciplines as a working science. The idea of my recovery uplifts them because the hero of the story is them, and their sane practices
(Razack, 2007, p. 385). They needed to see me as their version of a success story, in order to justify their (often violent) interventions on madness. Understanding me as cured justifies a continued practice of often problematic psychiatric interventions. This is the danger of what my voice and body can produce.

I can’t be here to rage against the machine. It is a trap to ask consumers to rage against psychiatry, to speak of its incivility, to speak of it as violence: this rage is only too easily reframed as a symptom of our madness, and quickly dismisses our language. At the same time, as often is in my case, in using the ‘master’s tools’ in the attempt to dismantle the necessity of Reason, we become understood as no longer an absolute Other – but rather, as recovered, and welcomed into the fold. I have attempted to trace how this happens, but remain unsure of how it can be otherwise. How can psychiatry recognize its own complicity and move from pity and pathology and into responsibility? How can consumer narratives be heard so that they “move beyond the individualist account to a ‘collectivist account’” (Razack, 2007, p. 390)? I conclude with the personal conundrum of whether I should stop speaking personal story at all, and wait until the categories of madness/sanity are disbanded altogether. I fear that I, that we, would have long to wait. Or whether this voice is still necessary in order to produce knowledge that might help to fracture such dualistic categories in their current formations. Basically, as I do this – how does it help, and how does it hinder?

6.3.3 Storytelling as Commodity

The opportunity to both reflect on my story as well as query the risks that it produces was a novel opportunity. To contrast, attempts to organize another talk on my storytelling circuit was quite the opposite experience. I was asked and agreed to give a plenary talk for a mental health organization’s annual lecture. I was told that the occasion was an important promotional event
for the organization, and that donors would be in attendance. This was tied to my role as a consumer research consultant – I was representing the MHCC/At Home/Chez Soi project through my personal story. It was different than presenting as a young scholar, where I am used to having control: writing my own abstract, bio, and presentation talk. Here, my consumer identity took lead: for this event, I lost control.

I was first sent a draft promotional poster for the event. Surprised, the title was being proposed for me without any previous discussion: *Escape from Hell: The street was my home*. Suddenly, I was an after-school special spectacle. I was both devastated and furious. The labour of composing a polite response was still something that I was adjusting to in my work role: I was still getting used to measured responses to insult. I wrote “I really hesitate with the proposed title “Escape from Hell: the street was my home” for a number of reasons. I certainly don’t think that I escaped from hell. There were a number of things that I experienced that I value. Further, I continue to be friends with, and support through the At Home/Chez Soi project, a number of people who have not left street life. I really would never want to insinuate that I had escaped hell – and that they had not. And finally, the street was never my home. Rather, it was a place where I spent time when I had no other recourse, but it was never my home – I was simply without one.” I feel how forced these words were to write, and I resented having to word them with such little force. I was training in respectability.

We went back and forth with titles; I felt the resentment rise, and that it was I that was being understood as difficult. I was put in a reacting role because I wasn’t the one acting. I was told this was the organization’s talk (not mine), and they needed something that would draw in a crowd. We settled on the (disputed) title “Living Homeless: my learnings from street life.” I wince; out of shame, out of helplessness. Then my biography: sent and then returned and asked
(under the semblance of being respectful and not intrusive) if I could acknowledge in it my history of housing instability and how housing changed my life. There was concern that my bio was too academic.

I was also asked if I would speak to the media to promote the event. I hesitated, and said that I would have to think about it. I did not want to speak to the media, and conveyed such. I was pressed. It was part of my job, to promote the project. I caved, writing that “I would rather not speak to the media about my personal history. I would, however, consider speaking about my work position on the project, and the value of hiring people with lived experience within mental health and homelessness research.” I was assured that the journalist was ‘one of the good guys’ in mental health writing, and had experienced depression themselves.

I took the phone call from the journalist from the space of the university tower. I was a PhD student, surrounded by smart and respected colleagues. It was a good space for me to take that call. The journalist started by probing my past. I immediately felt the set up to speak badly about my family. Questions probing for parental failures I would not divulge. The last thing I needed was a story blaming my family, rather than the legal, social, and systemic barriers that prevented me from accessing social services. I redirected by emphasising my research: I was a PhD student! She asked me my diagnosis. I told her I identified as a psychiatric survivor. She told me she could not write the story if I didn’t give her my diagnostic label. The call ended on that. The story never ran.

Suddenly, in the effort to promote myself as the solution, I had become a problem. I was not willing to perform as planned. Running the risk of a disappointment, that I would not disclose as was desired, project participants were added to the event. Closer to authenticity than I was willing to embody, they ended up speaking on their experiences of homelessness and being
housed through the project. They spoke of God, the hardships of homelessness, and gratitude to
the project for helping them. My talk confounded: I ended with a Nietzsche quote about enduring
the relentless fight: “that there should be long obedience in the same direction; there thereby
results, and has always resulted in the long run, something which has made life worth living”
(Nietzsche, 2008, p. 471). Meant as a rally to continue to fight for social change, it also secretly
marked my own battle to speak. The only audience question asked of me was a query: “I don’t
understand what Nietzsche has to do with it.”

Coming up to a year later, I ran into the organizational head that had both invited me to speak, as
well as who I had such contested negotiations with. They told me proudly that their planned
plenary speaker that year was a very prominent writer on mental health who had just published a
ground-breaking book. I felt that I was being told this in particular because I was to know that
the engagement that I had had the opportunity to speak at was a prestigious one. I was then told
that the prominent author ‘had been very easy and a pleasure to work with, and was excited to
have the opportunity to speak.’ This, I took, was measured against me.

He had a book to sell. I was supposed to feel ashamed, ultimately, for not selling myself.

6.4 Storytelling through the Psychiatric Gaze

By contrasting a few venues in which I have shared my ‘recovery story,’ I am showing in
particular how stories are mediated by those that speak them, those that hear them, and are
shaped depending on the context in which they are given. There is no true story. At the Into the
Light conference, my story, despite my attempts to speak otherwise, was largely interpreted as a
recovery narrative. This speech act led to other speaking opportunities, which highlights how
peer stories as a diversity and inclusion practice are hot commodities in mental health
assemblages. When I moved to tell this story within the context of a space that was welcoming of
critical analysis, I shaped it to allow for more room to think critically about what my storytelling risks. And in my attempts to tell my story in ways other than a tragedy-to-recovery narrative within the context of a mental health organization, my acts were understood as unruly, and my story disregarded while other people with lived experience were brought in to supplant it.

Storytelling by people with lived experience is currently promoted as the best way to solve the problem of stigma and discrimination. Because of this, storytelling is “frequently represented in benign, magnanimous, or positive terms in rationally-nuanced, master narratives” (Grant & Zeeman, 2012, p. 2). In what follows, I unsettle peer storytelling as having a purely positive function by elucidating some of the conditions, limits, and productive functions of peer storytelling. This means attending to “the settings in which storytelling is expected, required, or disallowed, the conventions adjudging what kinds of stories are considered intelligible or successful, and the rules governing how stories may be told, and when they may be interrupted or interrogated or ignored” (Polletta, 1998, p. 425). In this section, I start by exploring the problems that storytelling for social change invites more broadly, and then move to explore the specific limits of storytelling madness within the confines of mental illness discourses.

Narrating personal experience as political has been central to feminist, queer, racialized, disabled and other movements’ activism, and “cultural studies, anthropology, history and legal theory as well as sociology have emphasized narrative’s counterhegemonic, subversive, and liberatory possibilities” (Polletta, 1998, p. 424). However, critical reflections on the possibilities, limits, and conditions of storytelling have queried what is produced when we draw on stories to counteract metanarratives, as Razack’s 1993 article “Storytelling for Social Change” does within the context of social justice education settings. Razack shows how “there are land mines strewn across the path whenever story-telling is used” (Razack, 1993, p. 56), and asks how subjugated
knowledge through storytelling is put to use. Not only exploring the conditions under which these stories are possible to perform but also their performative value: she asks, how “will someone else take them and theorize from them? Will they serve to reassure everyone that Canada is diverse, full of folklore? Who will control how they are used? Will immigrant women tell a particular kind of story in a form that they do not control? Such dilemmas are evident whenever storytelling is used” (Razack, 1993, p. 56).

Critiquing the process of storytelling is a difficult thing to do. As Razack notes, we “shy away from critical reflection on the practices of those on the ‘good’ side. Ironically, our analytical and pedagogical tools seem to discourage internal critique by calling for respect for different voices with insufficient attention paid to the contexts of both the teller and the listener” (Razack, 1993, p. 65). The practice of storytelling for activism within mental health social movements has a long history (Church, 1995; Crossley, 2006; Morrison, 2005). Storytelling is a prominent way in which we have worked outside of the system to redress injustices caused by systems of power, as well as a way to assert our lived experience as power, value, and knowledge within such systems.

The stories that we tell are always mediated by the language in which we chose to tell them. As Rembis notes, “the narratives we construct determine our reality; they determine what we know to be true, and they have very real material consequences in our lives. They also define what constitutes … what we think we know about mental illness” (Rembis, 2014, p. 142). Our words are what are used against us to qualify our madness, yet voicing stories of resistance and oppression have been central in organizing against the psy disciplines. But what once were ‘forbidden narratives,’ banished from public hearing and contained to case files, have now become narratives workable to change, sustain and even promote mental health systems. The
peers that I interviewed all shared experiences of being asked to share their recovery stories in various contexts – it is central to the peer work that we are asked to do. And telling your story within a peer role as an employee, in particular, conditions the ways in which stories are speakable, heard, and used: often from resistant towards palatable narratives, that are heard as individual issues (the problem is within), yet are taken collectively to narrate an assembled story on how to prevent such occurrences.

Current mental illness paradigms set the stage for how peer storytelling is put to use. As I show, current regimes of truth that govern madness render recovery-oriented narratives as valuable. Stories that work outside such conventions trouble the foundations on which systems of power are built. Polletta notes, “the rules governing storytelling may help to define and sustain the very interests, boundaries, and mandates that constitute the institutions within which they are told. Storytelling’s content and context mutually sustain each other: what stories can be told on particular occasions endow those occasions with institutional meaning” (Polletta, 1998, pp. 425-426). Peer stories are confined by the larger national, institutional, and organizational spaces in which they are heard. Further, this chapter unpacks how peer “stories are differently intelligible, salient, available, and authoritative depending on who tells them, when, and for what purpose, and in what institutional context” (Poletta, 1998, p. 425).

Recognizing that storytelling is partial, mediated, that there is “no true self, no pure origin, it becomes all the more imperative to pay attention to how our multiple identities are constructed and played out at any one time and in any one context” through the act of telling our stories (Razack, 1993, p. 69). We risk reifying ‘the homeless mentally ill’ through our narrative accounts, as voicing experience rests “on a conception of the self as unitary and coherent. Language is seen as simply representing reality rather than constructing it” (Razack, 1993, p.
61). To critique how personal stories produce metanarratives of the ‘chronically homeless mentally ill’ risks being understood as denigrating people’s experiences. Here, I work to trouble not which stories peers speak, but rather their productive value: how systems of power have learned to incorporate such narratives to benefit their own interests as commodities that solidify regimes of truth; and how we build stories to facilitate our own inclusion. Fabris and Aubrecht sum up the complexity of narratives when worked through the psy disciplines:

> Within westernized narrative schemas, stories of madness have played a central role in the telling and retelling of histories of colonialism and conflict, enlightenment, eugenics, industrialization and urbanization, and control. Important critical analyses and critics of how such stories are used to perpetuate inequitable social relations can be found within Disability Studies (Price 2011) and Mad Studies (Costa et al. 2012). Geoffrey Reaume (2009) cautions that stories of madness, however prevalent, are rarely told from a mad perspective. When such stories are told, they tend to depict madness and mental illness as conditions that produce isolated individuals naturally at home in the shadows. (Fabris & Aubrecht, 2014, p. 193)

Thus, currently, peer personal stories that focus on social change are largely narrated as an overcoming of individual conditions with the goal of reintegrating back into normalcy, rather than marking how the social organization of normalcy is premised on excluding difference.

Part of my work as a consumer research consultant was to tell stories. It also became part of my work to support the solicitation of stories from other peers working on the project. Sharing stories of homelessness and distress as part of your work role changed the way that I was used to using stories. It added an impending concern that it was also a duty as part of my work role to the usual constraints of the who, how, when, where, and what for’s of storytelling. The constraints of storytelling under these conditions had me concerned. And others involved in peer, activist and advocacy work were wary of how peer storytelling was increasingly being harnessed. Aware and unhappy with how our narratives were being used to support and promote mental health and social service agendas, a group of psychiatric survivors and our allies independently formed the
Recovering our Stories Collective in Toronto, and organized a public event in June of 2011 at Ryerson University. The event was entitled “In Whose Interest? How psychiatric survivors can use our stories to change the world.” Featuring storyteller, poet, and critical thinker Eli Clare, we targeted an audience of service users, service providers, and academics and used the opportunity to intervene and query how we are all using madness and mental illness narratives, and with what effect and implications. We then wrote up an analysis of the event, which focused specifically on our concerns of storytelling for those who have been psychiatrized.

In “Recovering our Stories: A small act of resistance,” we describe the community event and the article’s purpose as motivated partially

in response to the appropriation and overreliance on the psychiatric patient ‘personal story.’ The sharing of experiences through stories by individuals who self-identify as having ‘lived experience’ has been central the history of organizing for change in and outside of the psychiatric system. However, in the last decade, personal stories have increasingly been used by the psychiatric system to bolster research, education, and fundraising interests. We explore how personal stories from consumer/survivors have been harnessed by mental health organizations to further their interests and in so doing have shifted these narrations from ‘agents of change’ towards one of ‘disability tourism’ or ‘patient porn.’ (Costa et al., 2012, p. 85)

We use the language of ‘patient porn’ to mark the interactive nature of consumer/survivor storytelling: “by pornographic we mean that, while some people reveal their most intimate personal details, others achieve relief through passive watching, while others still profit from the collaboration of those on the front lines in compromised positions” revealing their interior lives for consumption (Costa et al., 2012, p. 86). In this dynamic of being complicit in sharing your narrative, often out of financial need, yet not being in control of what angles are highlighted by the audience, unfamiliar with who views it, how it is consumed, and cognisant that others are reaping benefits far larger than you through the process, seemed apt. I have felt pleasure and shame, guilt and joy when the applause follows.
In making this intervention, we made clear that “stories are extremely powerful and have the potential to bring us together, to shed light on the injustice committed against us and they lead us to understand that not one of us is alone in this world. But our stories are also a commodity – they help others sell their products, their programs, their services – and sometimes they mine our stories for the details that serve their interests best” (Costa et al., 2012, p. 86). We wanted to mark how resistance narratives working against the system had been resignified through institutional incorporation into recovery narratives, and systems have worked to “absorb resistance accounts, sanitize them, and carry them forward in ways that are useful for them, without disrupting their dominant practices” (Costa et al., 2012, p. 87). Our stories are now used by “politicians and philanthropists, to build organizational ‘brand’ regardless of program quality, and to raise operating funds during times of economic constraint”(Costa et al., 2012, p. 86).

Further, peer involvement has proliferated venues and avenues for us to speak, and some of our own enterprises rely on storytelling as core to our mandate. For instance, consumer/survivor driven initiatives such as Toronto’s The Dream Team and Voices from the Street are ventures built specifically around training and trading speakers with lived experience out into various political, educational and institutional settings to learn off of our stories of marginalization. Part of the trouble that storytelling produces is that it can beget simply more of it. Crucially, as Polletta notes, one of the risks of storytelling is that it “encourages speakers to call for more commemoration, more storytelling, rather than calling for new legislation, more appropriations, better enforcement of existing laws, or an otherwise interventionist federal stance” (Polletta, 1998, p. 437). Storytelling as an inclusionary practice can work to negate the development of larger systems of accountability.

In the article, we describe the typical way that peer storytelling proceeds:
To popularize the message that mental illness affects us all, social service agencies have recently cornered the market on personal storytelling. For a twenty dollar honorarium and a couple of transit tokens, select psychiatric survivors are recruited and paraded in front of institution staff, patients, Board of Directors, and local politicians in an effort that the golden road to recovery will reveal itself—but only if you take your medication and listen to your mental health providers. Issues of systemic poverty and discrimination, an appalling lack of choice in services, and mistreatment are conveniently left out of the story. Favoured stories feature the uplifting message that with a little hard work and perseverance, you too can be cured. Common themes include: How this or that service saved my life; how this or that medication saved my life; and how this or that pursuit of a normal existence saved my life. (Costa et al., 2012, p. 89)

The banality of our own storytelling has become apparent at these speaking engagements: we are now used to, or even expect that, a peer will start the proceedings of any mental health event with a recovery narrative. A new ceremonial practice, it centers us as the key trouble in the story, diverging system and structural factors that operate beyond our power.

During the course of the At Home/Chez Soi project, peers and project participants alike shared their stories in a variety of ways in formal settings: in workshops, training sessions, conference presentations, and with the media. Most of us are expected and invested in using our stories, but the impetus for what such practice works towards is ambiguous and varied: self-healing, mutual understanding, stigma-busting, further funding, and/or policy change. What our performance produces is an open range. In what follows I explore how peers involved in the At Home/Chez Soi project speak to the productive possibilities and limits of speaking their stories of homelessness and distress, as well as reflections on the confines and conditions through which they can be told.

6.4.1 Purpose and Possibilities of Peer Storytelling

Peer involvement is based on this premise: we assert ourselves as experts by experience and demand participation to educate and intervene on current practices with the hope that it will
change fields of power. Yet for professional practice, one purpose for listening to our stories is to learn off of stories of madness: mental health policy and practice is aimed at prevention and management, with a focus on how to build resilient subjects that can fend off mental illness. And for those of us that fail, ours storytelling can lend insight into early identification and intervention measures that need to be in place so that professionals can identify at-risk bodies for intervention (see McMurty & Curling, 2008; Voronka, 2013). Thus, the performativity of peer storytelling is multifaceted, depending on where you are positioned in the process. In all the work that we do as peers, this is especially the case through the work of sharing our stories. The purpose of telling our stories is to educate those different than us. It is left up to us to educate professionals about how we are being oppressed through biopower. As Audre Lorde notes in her pivotal work on the dynamics of redefining difference:

> Whenever that need for some pretense of communication arises, those who profit from our oppression call upon us to share our knowledge with them. In other words, it is the responsibility of the oppressed to teach the oppressors their mistakes … Black and Third World people are expected to educate white people as to our humanity. Women are expected to educate men. Lesbians and gay men are expected to educate the heterosexual world. The oppressors maintain their position and evade responsibility for their own actions. (Lorde, 1984, pp. 114-115)

We depend on educating others as our entry point into peer work. Storytelling gives us formal occasions to speak that we would likely not have otherwise.

Many that I interviewed spoke of the possibilities of storytelling as central to anti-discrimination work, of both demystifying those with psychiatric histories as well as madness/mental illness. This is our work left to do. When I asked whether she felt that storytelling changes the discrimination people face, Sally, who had experience with storytelling in a variety of educational, on-ward hospital, and self-help groups, replied:
I used to think so. I think so. I don’t know. It’s hard to answer because when you tell your story in AA it’s empowering because everybody in AA is a person with lived experience, so it’s a community and it’s different. You don’t have to be concerned about your confidentiality or not as much anyway. You don’t have to be concerned about the media or like all of these kinds of external concerns because the purpose of the group is different, and you are telling your story to help other people get better. But in this other kind of context, it’s a different role where you are trying to create awareness and you basically have the role of a spokesperson, so it’s hard to say … You can’t say staying silent would be better. . . When I was in recovery I did not get a lot of exposure to any other people with mental illness or through video or film or whatever. But I mean, does it change people’s opinion? Like, I would hope so.

Sally marks space and context as a condition of the work that storytelling can do, whereas Norman speaks unequivocally positively about “helping someone else, by telling their story.” But Norman articulates that storytelling is also part of his culture, and “people recognize that it’s a cultural thing… My community recognizes me as an orator and keeper of stories.” Norman values his role in sharing stories at events and enjoys doing it across communities: “And that’s nice to have that, people have come to expect that and I’m able to do that in a professional manner too and it leaves everyone happy.” When pressed as to whether he differentiated between the practice of storytelling within his communities versus for social service organizations, he said that it didn’t weigh heavily on him, as long as they take “away from the story something that they could use in their own travels.”

Others spoke about the positive productive value of storytelling by shifting expectations of who ‘the homeless mentally ill’ are. When I asked Heyoka about what her experience of speaking in front of an audience of professionals was like, she laughed and replied “they gave me a mug [laughter].” She went on to speak of encounters with “people who seemed really surprised. I think there are people who have been really invested in the stigma of mental health. They’ve been working in this industry for so long that they were surprised that I was so articulate and
could be professional and then also that I acknowledge mental health issues and homelessness in my history… I felt surprised. I didn’t feel judged really, just kind of surprised.” Here, the work of storytelling is used to counter, through articulations of difference, the notion that we are not so different after all.

Sally spoke of using her body and story to shift notions of mental illness in the context of the classroom: “after I finished speaking [the students] were all in shock, like they are all just staring at me because I don’t think they really have an understanding of what somebody with schizophrenia might be like. I try to demystify it because I find it’s a really interesting experience … I mean there is no other way you can look that closely at yourself willingly and get that, so when you come out of the psychosis if you can retain what was false and what was real and use it usefully. It can be an instructive experience, I think.” Part of our work through storytelling is to open our bodies up as intelligible to others to counter prevailing meta-narratives of the ‘homeless mentally ill’ as the abject deserving poor. We work to make sense of what is deemed nonsensical. But peers also reflected on storytelling as a process of navigating fraught and contested terrain.

6.4.2 Storytelling as Central to Peer Work

Most of those interviewed were able to identify moments when they were asked within their work context to tell their personal stories. It can be a difficult request to refuse when a condition of our inclusion is predicated on speaking the knowledge we’ve learned through lived experience. And that such experiential knowledge accrued is largely understood as personal insight rather than conceptual knowledge about systems of power. As Sally noted when reflecting on the position she was put in when asked by her employer to tell her story, “Well, that’s difficult to refuse because you want to do a good job, you want to leave a good impression
… like I did feel like you are kind of obligated to do certain things.” Saying no to such requests within an employment role produces risks, including that you are refusing to do your job.

Bob reflected on the first time they spoke on behalf of the project as a peer, noting at first it felt “awesome and it was funny and it was relevant … But then there was a huge sense of like loss and emptiness and I think that's because—and I've said this before—but I think it's because this is all that I have. Like speaking about my mental health and my addictions or whatever … that was all I had. Like that was everything. So when I put it out there and everyone eats it up, then I don't have anything now.” Giving up your story and allowing it to be consumed for others pleasure with impunity and without implication is marked here as an ongoing loss.

Telling our story can also come easily, as most have us have recounted stories in social service and therapeutic interventions, as a condition of trying to get our needs met. Bob, who previously noted that the effect of storytelling can leave one empty, also reflected that constructing one’s story felt natural: “It didn’t take any effort or really any preparation. I could just tell it at any time to anybody.” Those who have been through the psychiatric system are used to telling our personal narratives: they are the ways in which we seek, access, and sustain help. As Debbie noted, storytelling “is how we access services, right?” Most of us have had to reveal ourselves to gain housing, mental health, and other social support services. We have spent substantive parts of our lives working with psy professionals rehashing our narratives in the hopes of making sense of us, others, and our place in the social. Long used to sharing our innermost thoughts in private council, shifting that to public venues can sometimes come too easily. Given our exclusion from educational and professional environments, our stories often feel like all we have, and all that we know to do. Anne, in reflecting on the similarities between therapy and storytelling, sardonically noted “it’s almost stigmatizing in itself because it’s just sort of like, I’m
able to talk about myself because that’s what I’ve been doing for the past 15 years is talking about myself, so why don’t you give me another talking about myself venue, great.”

Anne also reflected on how the nature of peer work is so often tied to our own and others stories, and how the psy disciplines (including the recovery movement) has generated a political economy out of storytelling. One of the peer roles she held working outside of the At Home/Chez Soi project was on a recovery research project, and was asked as part of her work role to write a recovery blog: journaling and disclosing the ebb and flow of her own state of being. In this passage she makes connections to how recovery stories are tied to neoliberal regimes of self-governance:

There’s like a pattern to those stories, they are like AA stories, they’re like these rags to riches, like practically American dreamish stories and I think [that is] the ideology behind recovery. I noticed that when I went to [a university] which is an incredibly conservative place and even [a peer researcher], although she’s very cool -- it’s what they’re selling behind that, what’s behind recovery when you really think about it is well, we’ll just get right back to work then. It’s very tough loveish which I don’t like. I don’t think it leads us necessarily in the right direction in terms of a more compassionate society, in terms of people caring, even talking about difference as being important.

The return to normalcy recovery narrative common in current peer storytelling is an entanglement: stories are often all we have to start with, and they are that which can qualify us into peer roles. In order for us to find employment we have to promote ourselves as recovered, as well as supportive of the recovery model. Anne notes that despite being critical of the recovery model, “as a consumer you need recovery to be promoted if you want to be employed, so that is the position.” To query the position that recovery rhetoric puts us in can put us in a compromised position.

Anne also noted how our stories are being used by mental health researchers. In speaking about her work with a researcher outside the mental health field, she spoke of how the researcher is
“trying to jump into mental health because this is a more lucrative field at the moment, where there are more grants.” She characterizes the researcher, a narrative anthropologist, as coming in and learning “about us, then you take our stories and then you advance your career. Meanwhile as peers we are telling the stories. [But] this is your data and your research, which you are going on with and the value of my story has so much value to you because my story helps you advance.” Anne then reflects on how this is similar to the debates that took place in the field of anthropology in the 1960’s, yet when the stories stem from the mentally ill, this is still predominantly practice left unquestioned in mental health research fields. Sharing our stories risks having others mine our stories to their interests. As Jackson noted during her interview: “That’s why we have to become much savvier and understand that no matter what you do it will be co-opted. There is nothing that you can push that isn’t eventually going to be co-opted and turned into its own thing, and so if you can understand that going in and have a strategy of exactly what you’re going to do the moment it starts to be co-opted … because with storytelling, like, that’s happened.”

6.4.3 The Codified Story: Who Speaks, and How We Speak
Peer also spoke of concerns over who gets asked to share their story, as well as the implicit and sometimes explicit conditions under which we mediate our stories. In this way, peers recognize how our stories of marginalization now follow codified narratives of recovery. Tal explains the process through which individual stories become cultural narratives as a process of cultural codification, whereby stories of marginalization are processed and interpreted through dominant culture, and become “a contained and predictable narrative” in which “narrative form gradually replaces content as the focus of attention” (Tal, 1996, pp. 6-7). A few interviewees noted that those that get asked to share their stories are often those that will easily fit within the ‘from
illness to recovery’ narrative: as Debbie stated, “It’s like storytelling is formulated. It’s got a default narrative where you change a few of the adjectives around … you fit into the narrative.” Claire also noted how narratives are predetermined before one even speaks: “they had a preconceived notion of what they wanted their story to be and they were just looking for me to fill a couple of sentences: ‘oh, okay we need a tragedy story so give me your tragedy and we’ll fit that in there’.”

Those that are most willing to actively fit themselves within dominant metanarratives are often those approached to speak. Jackson notes how “they are very careful about who they pick and put out in front of the media.” Lee speaks to the often unspeakable frustration of the ‘usual suspects’ being approached to speak. Reflecting on one peer who is often asked to speak publicly: “this person is a person who can be seen as a yes person. And I didn’t like – it infuriated me. I was really, really, really upset. And I couldn’t convey that to anybody. I couldn’t convey it to the person. I couldn’t convey it to the project, that they chose this person [to speak] for so many things because of that [yes] view.” Who gets asked to speak is mediated by organizational interests. In my role, I had a number of discussions about which project peer or participant would be best suited to speak at public engagements. Those who were critical of the project were not chosen. Those who were disruptive, non-compliant or ‘risky’ were often spoken of and understood as ‘deteriorating’ or in a mental health crisis, and thus deemed not suitable to speak. A condition of speaking was wellness. Often, dissent and mental illness were conflated.

Many peers reflected on what they don’t disclose when narrativizing their accounts. Sally spoke of how “it can be a bit draining to bring all your personal details out and all that stuff. So I tried to minimize all the super embarrassing things and the craziness of it that I know people will react badly to.” Heyoka reflected on trying “not to go into to many details about things, or I don’t want
to talk about my deep emotional pain, you know [laughing].” Norman spoke of how “each of us as human beings do have certain private parts of our life that we would rather not tell in public … because that could come back to bite you later, you know.” When asked if that had happened to him, he reflected “I know when I’ve gone, you know, a little too far and I know I gotta tone it down and sort of come back. And even in some cases I’ve had to retract or to make a public apology. I’ll do what it takes to regain myself.” Part of the condition of storytelling for peers is to normalize and sanitize narratives of madness and homelessness for palpable consumption. Some peers have gone through training, such as speaker’s bureaus, on how to give the right kind of story. Lee speaks of how “we were trained on how to not complain, but tell the facts. Tell your situation. But not complain, not to get angry, to channel our anger, how to use it effectively. Leadership skills and how to build relationships and things like that … But in terms of telling your story, we were trained in making it concise, pulling it in. But not how to write it or what view to write it through, or how personal to get, or anything like that.”

On the other hand, stories can also be too uplifting. Sally referenced a time after speaking at a hospital to a group of people institutionalized for psychosis when “the service provider told me I was being too positive, so she told me to tone it down next time and stop giving such an unrealistic picture.” When asked why her story was deemed unrealistic, she said that the service provider felt “well that’s your reality for you but it’s not other people’s realities and they don’t have the same kind of capacity that you do … or they shouldn’t understand that they can emerge stronger and better than they had before they got sick.” Sally’s narrative of psychosis as surmountable, and even valuable - a narrative common within recovery from psychosis groups such as Hearing our Voices - was understood as putting at risk those who might not be able to rise to recovery.
Another trouble with peer narrations in particular is the difficulty of hearing such mental illness narratives as socially constructed and co-constituted. Because madness is currently understood as biochemically-derived, madness has become a problem of science and disease, and thus not understood as socially produced. When social factors (such as race, sexuality, gender) are considered, such ‘difference’ within the assemblage of those who have had contact with the psy disciplines is addresses through the paradigm of social determinants of health. While this scholarship is useful in elucidating how social injustice disadvantages particular individuals across the identity landscape, such as higher diagnostic rates of schizophrenia in Black men, greater risk of suicidality for those queer-identified, or greater depression rates in women, it positions such identity groups as at greater risk of exposure to mental illness while still leaving mental illness as a field of power intact. Through the incorporation of social determinants of health discourses as added to recovery narratives:

mental illness, in this approach, is essentially figured as the result of social injustice. While laudable in attempting to raise social questions to the overarchingly individualistic disciplines of psychology and psychiatry, this approach, however, fails to question psychiatric authority and its diagnoses, including “depression” and “schizophrenia.” The result is that this approach merely supplements a medical or biological model by providing complementary social explanations. It fails, however, to account for how marginalized people (such as the poor, colonial subjects, racialized people, queers and gender variant people, the disabled) tend to get disproportionately diagnosed or pathologized by the psychiatric profession, and how the psychiatric profession has been implicated in processes of colonization, racism, sexism and heterosexism, as well as in disability and war-making. (Howell & Voronka, 2012, pp. 2-3)

In this context, ‘difference’ through social determinants of health frameworks is understood as compounding the risks of becoming mentally ill, but it leaves mental illness as a basic premise intact. Querying mental illness by speaking, as many do, of the ways in which distress is socially produced (many speak of their distress as originating from trauma) shifts understanding of mental illness as hereditary/biochemical towards being socially produced. Yet mental illness
itself is still reified through such accounts. And contesting mental illness in these narrations can simply reaffirm diagnostic categories in the way that they are heard. The audience can read the refutation of diagnostic categories as a sign of mental illness – the patient has no insight into their own mental illness.

For example, Rachel spoke in detail about the trouble of speaking about mental illness or madness outside of the boundaries of individualized discursive regimes. During an event organized on social justice and mental health:

We would talk about mental health in a sociological context rather than a psychological one. Some people completely didn’t get it and resisted it in every single one of its forms, and even the people who were really into it kept slipping back into individualized language and basically just wouldn’t answer our questions, either because our questions were ‘too academic’ or were not framed properly or because it just would just make their head explode. And even though they wanted to, they wanted to and they couldn’t, and I think that we have so much work to do to locate mental health in its [social justice] context.

How we are able to speak and be heard is limited. Breaking from the script of the tragedy to triumph narrative is difficult because, as Debbie notes, stories often speak to “how we fit into structures, and not how we create structures, because the structure was already there when we got here.” She notes in particular that more political narratives of incarceration/imprisonment “are alternative models, but it’s more rare.”

In this way, we tell our stories in ways which present us as abject bodies working towards becoming redeemable subjects. As Woolford and Nelund’s (2013) work on the responsibilities of the poor in Winnipeg notes, “either strategically or inadvertently,[the poor] learned to inflect their public speech with neoliberal discourses in order to present themselves as whole rather than discredited persons” (p. 313). Most often edited out of our storytelling are the ways in which we narrativize our madness and our badness. The stories of us as perpetrators of criminality,
violence, abuse and so on, when referenced, are often minimized and rarely expanded on. We position ourselves as good, sometimes as doing bad under dire conditions, but once we have needs met, restore back to good. Jackson references the omission of what she calls the “ugly stories” as working to gloss over the complex nature of who we are, and how and why we act. Our desire to be seen as, and the systems’ need to position ‘the homeless mentally ill’ as good citizens gone astray and restorable through incorporation operate together because we need to be deemed worthy of investment and rehabilitation. Jackson predicts that “if the media were to go any deeper than just, like, tell me your vague story it would scare the shit out of the Commission. If I think about all of the [peers] and what I know about them and who they are in the world and all of the ways that they just exemplify all of the reasons why people have the ideas [about us] that they have in the first place, it’s like they would have no interest in ever putting these people out [there].” Thus those of us with stories of criminality and violence learn and act to silence that voice, in the name of stigma-busting and normalization. A condition of storytelling for stigma-busting is a sanitization of our transgressions.

6.4.4 Attempts to Control the Narrative

A number of peers reflected on the purpose and goals of peer storytelling, and spoke of developing strategies for narrating their accounts towards social justice action. When asked what the purpose of storytelling was for her, Rachel reflected “I think in the peer context there’s often some confusion around what the point is and I didn’t know why I was doing it. I didn’t know what the point was and I think we felt a little sick afterwards because nobody cared.” Rachel goes on argue that we as peers need to think more critically about how we share our narratives, for what purpose, and with what end goals. After telling her story:

I felt like, well, was that really worth it? Now when you google me you get like mental illness, was that really worth that I don’t know. I don’t think so. I don’t think I got much
out of it personally. It felt a little bit exploitative and I think storytelling can be very powerful, it’s not always and it’s not a given, everybody has to know why they’re doing it and what the risks are, what the point is and if it’s really for social change, if it’s really to try to convince … to really bring somebody over to a way of thinking that they weren’t thinking before. That’s one thing but if it’s to trot someone out as an example so that you can feel good about yourself that’s not the same thing at all. So who is in the audience, what is the point I think those things need to be looked at, I think that they’re not givens.

Others spoke of having a particular intent beyond stigma-busting behind telling their story.

Claire spoke of working her narrative to point to systems gaps and failures. She shared an example of strategically accounting the story of how it was easier for her to receive housing services as an abused woman than as a mentally ill one to point to system-gaps:

I talked about how one time I was homeless because I fled an abusive relationship and I went to a transitions shelter for women … I said in a way that it was a good thing that my husband turned out to be a jerk because I ended up in a shelter and I was able to get a social worker who did outreach and because of her outreach – because there were more services for victims of crime than there were for people in the mental health system alone, I was able to get the extra support I needed … And so that was a point about the system. That wasn’t about my marriage. That was about the system and what services are available in the community.

Others reflected specifically on disclosing personal narratives as a way of promoting peer involvement: it is difficult to speak of the peer participation imperative without locating yourself within that narrative. Heyoka spoke of using her narrative to get to the point of promoting peer engagement: “I did say, you know, I had been homeless with my kids and when it was. And I mentioned my long history of dealing with mental health challenges. And then I talked about how that was useful to me. I know that I was there as a peer and that my personal goal, and that presumably the goal of the project inviting me to go there and present as a peer, was to help the whole, getting peers involved. And so I talked about how it was positive and how I felt it was beneficial not only to me but to my team.”
Some felt that storytelling was a privilege, to be able to voice perspectives that others were not in the advantaged position to speak: Sally spoke of a “moral obligation” to make visible subjugated knowledges. Lee spoke about the boundaries she has developed around when she is willing to share her story, and the difference of storytelling for peers and speaking for organizations. She spoke of sharing her narrative to mentor others in similar situations – “I’m sharing it for a reason. I’m sharing it to protect someone else... It’s a process to help others. And it’s a process to educate. And that’s the only time that I’ll feel comfortable sharing my story. Other than that, no.” She spoke of how another organization “wanted to put me on Youtube and make something like a video” to promote their initiative. Lee differentiated between helping others and being used for organizational promotion – “that’s where I would draw the line. That’s using me for [their] initiative.” Using our stories to maintain and enhance both career and systems ambitions, often referred to as poverty pimping, is one of the landmines that runs rampant through storytelling. It is not just within traditional mental health, social service provisions, and research that this technique of power prevails. Implicated too is critical work like my own, which regardless of my ‘lived experience,’ renders me complicit. As Diversi and Finely reflect: “We advance our careers by doing research and representing humans in poverty and oppression. We may try our best to do so with conscientiousness, ethics, and the best of intentions toward social transformation. But it seems ontologically and epistemologically foolish, at best, to ignore the visceral knowledge that we, Postcolonial scholars, walk a blurry line between empowerment and exploitation of the downtrodden” (Diversi & Finely, 2010, p. 15).

6.4.5 Stories as Risky Business

In sharing our stories, we risk reifying accounts of the ‘homeless mentally ill,’ regardless of whether we try to fracture our accounts outside of dominant metanarratives. We also risk
representing ourselves and the collectivities for which we speak as static, a generalizable and
knowable body. As Polletta notes, “the protagonists of stories stand for larger groups or identities
... The danger is that the story presents a unitary picture and obscures differences within a group
or experience” (Polletta, 1998, p. 440). Along with the politics of representation, “storytelling
objectifies its subjects, confers a kind of fixity and stability on them. An activist may be trying
more to make sense of what is happening around her than to mobilize participation, but when she
tells her story of the collective ‘we,’ she is helping bring that identity into being” (Polletta, 1998,
p. 423). Our stories risk rendering us as being understood as knowable subjects, which can
discount our variant and subaltern histories of becoming that operate outside of cohesive
comprehension.

Debbie spoke about the limits of being able to speak her story, “words are sometimes
inadequate,” especially when being asked to draw on her ‘homeless mentally ill’ experiences, as
they negate her full identity and restrict her from representing herself in multiple, even
contesting identities. Here she uses the analogy of multiple hats to represent the fracturing of her
subject/subjectivities through the constraints of narration: “you want me to wear the purple hat,
but actually I like the green hat. This is green hat weather. I want the opportunity to say ‘no, I
want to wear my green hat today,’ or I will wear the purple hat, but I want to wear it on this side
of my head ... I want to tilt it to the left instead of the right. And you find yourself bumping up
against things. The hat falls off, or someone knocks it off. So like if we want to wear the hat a
little differently – but, no, the hat goes on this way.”

Another prominent issue, in particular when we are asked to speak on behalf of organizations, is
that our stories can work to affirm and entrench prevailing understandings and interventions
made on behalf of ‘mental illness.’ This is especially so if our narratives are easily framed or
understood as ‘recovery narratives,’ as they can work to constitute both existing systems and individual service providers as successful in their interventions. Razack notes how audiences can be drawn into hearing stories without considering their complicity within the matrix of oppression that is being revealed: “I have seen students literally feeding off the tears of stories from the Third World, basking in the sense of having visited another country so easily and feeling no compulsion to explore their own complicity in the oppression of others” (Razack, 1993, pp. 66-67). When hearing recovery stories, rather than feeling complicit in contributing to the tragic narrative strains that speak of oppression, listeners can rather hear themselves as being a part of the recovery narrative. Not as part of the problem, but rather as part of the solution. When Bob was asked why they thought our peer narratives were so eagerly consumed and applauded, he reflected: “It gives them evidence. It gives them kind of – “it qualifies why I’m doing what I’m doing,” right? I think maybe that’s what happens. And again, they’re probably not conscious of it. But I think that’s what it does.” Our narratives can work to construct provisions and providers as the saviours of our story. And if current systems and provisions are heard as working to save us from ourselves, it risks retrenching the status quo.

The most prominent way in which peers spoke about the risks of storytelling had to do with self-risk in relation to media representation. I cannot overemphasize the amount of work that peers and project participants put into sharing their stories with the media. We speak to the media for personal reasons, for professional reasons, and for social and mental health systems change: colluding with self, project and Housing First philosophy promotion. Speaking to the media was always framed through ‘choice;’ the notion that peers and project participants have the choice as to whether they want to speak to the media. But much like Housing First, this choice is constrained. To begin with, we often have limited choice in how we access our power. Our stories currently hold valuable currency that sets us apart for the other professionals working on
the project: it is what we can most readily mobilize and use to justify our work positions. As ‘experts by experience,’ stories are what we have that other experts do not; or do not have to disclose. And we usually get paid to tell our stories. Further, limited choice in that while we can chose how to tell our story, we have little choice over how that narrative is represented, how it is heard, and how it is taken up and away by the media and public. Finally, storytelling is often understood as a condition of our inclusion. It is how we give gratitude back to what has been given to us. We should share our stories of employment, of being housed and recovering from mental illness, by ‘giving back’ or ‘paying it forward’ to the interventions that have helped us. Taxpayers deserve to be rewarded for their mandatory benevolence.

Many peers workers experienced trouble after speaking their story to the media, which lent to considerations of whether it was well worth the risk. Lee spoke of sharing her story on film, and how “viewing it for the first time made me cringe. I actually had my arms and legs wrapped around myself, because I was feeling exposed.” Another peer, here anonymized because of ongoing fears of having their child apprehending by social services, spoke of the consequences of having shared their story in the media in the past, and how that prevented them from securing an apartment unit for them and their children. While looking for a rental home, a landlord googled their name, realized their past, and went back to them saying that “I was poor. You live in poverty. You can’t afford this.” It put both their and their family’s housing security at risk. “I was really taken aback at how something in the media could affect you years down the road … It was devastating at the time.”

Clair too spoke at length about her experience of speaking to the media on behalf of the At Home/Chez Soi project, which caused her great trouble:
In the end I was really upset about the representation that did appear because, oh, every
time there’s a news article it’s heavily edited and it’s just a few snippets and they chose
to focus on my homeless story, one of them. I was homeless four times and I told the
story of how I became homeless one time, and that was how they opened the article. And
you know, it made me sound, well, crazy, and they didn’t use any of the things that I
wanted them to focus on – which was peer involvement in the project. They weren’t
interested in that at all … it’s an innovative thing in this big project, it’s involving peers,
it’s progressive and it seemed like an interesting story to me. But all they really were
interested in was ‘how did you become homeless’ and the rags to riches kind of angle.

Clair then speaks to how her story was misrepresented, which led to her “looking like a liar,” and
she received an “angry email as a result of that.” Whenever we narrate our story, we are
inevitably implicating others in it, and friends and family members might feel maligned by how
we narrate our stories, as they have counter-stories of their own.

Clair speaks of trying to rectify the representation by writing “a letter to the editor asking them to
correct that and they ignored it. They didn’t print it, they didn’t respond to it. And then I asked
[the MHCC Communications Department]… if they could advocate on my behalf and they
didn’t. So that error is still online and one of the reasons I cringe because it really hurt my
credibility, I feel.”

Clair also spoke of how the language of ‘consumer’ does not translate as media friendly
language, and mental illness and particular diagnostic categories are reified when relayed
through news media accounts. While Clair herself had no issue with being identified as someone
with mental illness, the reporter was unwilling to use the language of ‘consumer’ in the storyline,
as “it’s not headline friendly.” When I asked Clair why, she said that it’s because it doesn’t make
sense to the general public. When I noted that the point of our work was to change the way that
the public makes sense of us, she agreed, but recounted that language “was something that they
were not willing to budge [on]”.
6.5 Storytelling Superstars

With the rise of the recovery movement, coupled with celebrities using their status to support philanthropist causes, in recent years people have begun to use their exalted status to ‘speak out against’ mental illness. This includes those affected, as well as families, friends, and allies using their stories to help bring mental illness ‘out of the shadows’ through storytelling. Often we are told that mental illness is a silent disease that remains unspoken because of the stigma and shame that the disease evokes. But in recent years, a plethora of stars have lent their names to bolster support for mental health causes and anti-stigma campaigns:

In the last decade, as capitalist societies have emphasized the substantial losses in productivity associated with mental illness and the potential profit inherent particularly in pharmacology (Whitaker, 2012), personal stories have entered the marketplace (Jamison, 1997; Steele & Berman, 2001). Campaigns to normalize mental illness feature well known ‘talking heads’ who use their status and public profile to propagate the message that ‘it can happen to you.’ In Canada, they include broadcasters Shelagh Rogers and Valerie Pringle, singer Steven Page, and Margaret Trudeau. (Costa et al., 2012, p. 89)

Despite ongoing metanarratives of the need to ‘break the silence’ on mental illness, mental illness discourses have only been proliferating in public and popular discourse: this is how stable notions of mental illness become possible. Foucault, in *The History of Sexuality*, showed how in the Victorian era, discourses of sexuality were framed as unspeakable, yet sex as a productive function was harnessed, investigated, reworked and one of the outcomes was that sex as an activity came to define subjects and subjectivities. In our current moment, the same can be said of mental illness. While metanarratives of mental illness as unspeakable continue to dominant public discourse, at the same time official texts, media profile and public talk are all preoccupied with speaking up and against mental illness.
In the early stages of its formation, the MHCC worked to identify and connect with people of prominence who would work as good spokespeople for the plight against mental illness. Stéphane Grenier, a retired Lieutenant Colonel who served with Roméo Dallaire during the Rwandan Genocide, as well as in subsequent deployments including Somalia, joined the MHCC in 2010. Both Grenier and Dallaire have been outspoken about their own experiences of Post-Traumatic Stress Disorder (PTSD), understood as a result of the stress of military interventions. They both actively rely on storytelling as circuits through which to advocate for mental health service investments.

Razack (2004) explores the productive function of trauma narratives as voiced through Canadian military peacekeepers. She shows how Roméo Dallaire’s individual story became a national narrative which ultimately allows “Canadians to tell a story of national goodness and to mark ourselves as distinct from Americans. Peacekeeping makes it possible to proclaim a history of ‘doing good’ and ‘maintaining order among the fractious nations and people of the world’” (Razack, 2004, p.35). Yet Dallaire’s story also shows the danger of Canada as a middle-country power sending peacekeepers abroad, and he becomes “a symbol of ‘the level of impotence that Canadian soldiers have experienced during recent peacekeeping missions.’ His plight is the plight of a nation, a nation destined to be sidelined by the United States” (Razack, 2004, p. 25). Celebrated but also constrained by Canada’s peacekeeping role, peacekeepers with PTSD pose a problem, and “if we are to fix the trauma … we must offer counselling to peacekeepers and either refuse to send our soldiers into situations where they can do very little, or prepare them better for the little they can do, an argument that anticipates those who call for increased military spending” (Razack, 2004, p. 22).
Through such stories, we come to understand Dallaire as a figurative representation of all military personnel who are “psychologically scarred because of inadequate military funding. Unable to help wounded civilians dying in the street” (Razack, 2004, p. 28) can lead our Canadian soldiers into becoming mentally ill. Our peacekeepers become the primary victims of war, as narrative testimony displaces the Rwandans themselves who are silenced over by the “story about the civilized West in a primeval encounter with evil” (Razack, 2004, p.19) in the heart of Africa. Through such stories, Dallaire, and subsequently Grenier, have both become national figures whose stories build national narratives of Canada as humanitarian, yet one that needs to increase its mental health investments in order to maintain itself as a civil society. In this way, individual subjects such as Dallaire and Grenier, through their storytelling and subsequent celebrity, become figureheads “exalted above all others as the embodiment of the quintessential characteristics of the nation and the personification of its values, ethics, and civilization mores” (Thobani, 2007, p. 3).

Stephane Grenier has worked both within and outside of the Canadian military to rectify this crisis of PTSD amongst military personnel. Because of his experiences abroad, “in 2001 he coined the term Operational Stress Injury (OSI) and conceived, developed, implemented and managed a government based national peer-support program for the Canadian military” (NSB, N.D., p. 2) Subsequently, he helped “the launch of a second highly successful non clinical mental health program that now delivers ‘peer based’ mental health education to over 20, 000 military personnel per year” (NSB, N.D, p. 2). Both Grenier and Dallaire, in narrating their own lived experience, have drawn attention to the crisis of mental illness running rampant in the Canadian military. Different than civilian madness, the military is understood as producing distress through soldier encounters with the barbaric practices of wars waged in primitive lands, with savage peoples, through a lack of preventative and post-war mental health care, and thus should be
responsible for intervening and caring for it. Through Grenier’s work at reconciling this crisis through the development of peer support programs, the military is now conceived as doing something about the distress it puts its soldiers at risk of developing. Further, the Canadian military has now also become understood as a leader in peer-support based services (Money et al., 2011).

When Grenier joined the MHCC on assignment from the Canadian military, he spearheaded a number of peer projects, including the development of Guidelines of Practice for peer support in Canada. He left the MHCC to develop the Peer Support Accreditation Certification (Canada), an organization that is working to professionalize the field through the standardization and certification of peer support workers. In his time with the Commission, he was an authoritative figurehead who drew attention to himself, peer support, and the MHCC by sharing his story as an entry point into the work and the organization. Other prominent figures have been drawn on by the MHCC to raise their profile. In 2012, the actress Glen Close and her family were keynote speakers when the MHCC hosted the biennial 5th International Stigma Conference in Ottawa. The interest, draw, and subsequent press (in the following days, Glen Close and the anti-stigma story made the cover of numerous Ottawa and national newspapers) garnered when superstars speak of and on behalf of mental illness works to retrench biopolitics, as our stories are always turned into narratives larger than simply the ones we voice.

Peers that I interviewed were wary of using lived experience to become superstars. They spoke of telling stories out of goodwill, and not to “get some acclaim” (Debbie), nor “being interested in being some celebrity because I used to be homeless” (Claire). Peers have to be careful to situate their storytelling towards common good, and not individual interest, and we govern each
other when we think someone is using their stories for personal promotion. As Lee notes: “I was not to be a star. I was not to outshine the project.”

6.5.1 Our Stories Added to National Narratives

While discursive fields harness our individual stories to garner support and funding for mental health, housing and social support services, Jackson points out that storytelling is also used as a vehicle to facilitate wider debates in the general public. Common conversation within the Commission was that our work was to change the ‘bad guys’ minds - those that were not already on board with liberal ideals of the salvageable subject. Our job was to change the minds of those that were against us, those that understood the homeless mentally ill to be deservingly so. This worked at best to minimize, and at worst disregard the complicated nuances within the ‘good guys’ politics and practice to make room for the ‘real target’: those that were against us. Issues such as language, involuntary restraint, coercion and Human Rights were marked as too contentious for public debate: for public debate, the goal was to humanize us, to put a human face to the crisis of mental illness. It was those who still construed ‘the chronically homeless mentally ill’ as at fault, rather than through the fault of biologic or socio-economic consequences, that needed a broad and gentle education on the matter.

Through peer stories, our work was to shift conversations from ‘the chronically homeless mentally ill’ as a population, towards understandings of us as individuals with human stories. Through individual recovery stories, especially ones that end with us as back to work, wider narratives can be built of us as a population that is restorable and recoverable. Canada as a nation is built on the premise of humanitarian acts, a space which offers asylum, life chances, a belief in new beginnings, and investing in the social realm with hopes of a positive return. In this way, our recovery stories offer us the opportunity to position ourselves as redeemable Canadian neoliberal
citizens, emphasizing “active engagement with the world of work, prudent risk management, autonomy from social support, and entrepreneurial acumen” (Wollford & Nelund, 2013, p. 293). Our stories speak to larger national narratives of working towards respectability, and in doing so, we tell stories that “adapt to the neoliberal bureaucratic field, and thereby seek to perform the citizenship qualities necessary to convince gatekeepers that we are worthy of care” (Wollford & Nelund, 2013, p. 293).

In efforts to bring a human face to the problem of ‘the chronically homeless mentally ill’ as a population, our individual stories are harnessed and added to the assemblage of regimes of truth that make up metanarratives on homelessness and mental illness. Jackson notes that peer storytelling is used to generate wider debates about who we are as a nation, such as how our tax dollars are to be used, through the microcosm of peer narratives. The media profiling of personal stories of homelessness and mental illness evoke questions on which Canadian subjects are worthy of support, and ultimately, what to do with the trouble that the homeless mentally ill create:

the problem with the whole conversation about media representation is, when someone is asked by the Commission to participate in an interview there is this implicit sense that they are being asked to help deliver on this overall goal [of good]. But the problem is, is that it actually isn’t in peoples best interests. So I never pushed the media stuff because it’s not in peoples best interests, in fact, to speak about it. Because all it actually is, is it provides the opportunity to have a debate. People get used as a pawn to have a debate. Why is the Commission interested in media coverage at all, if you read the comments section of most newspapers or if you listen to the fallout. It’s like a [peer] member, a fucking National Consumer Panel member, whoever, is put out there, and their purpose is to actually generate a debate. It’s just like so cold.

The problem of the homeless mentally ill is a spatial one: it is intimately tied to race, colonialism, homophobia, disability and other nexuses of discrimination that results in
displacements, migration, and ongoing colonial, economic and sexual violence within this nation. But hegemonic discourses continue to map individuals as the problem: as Kawash notes, “the ‘homeless problem’ as it appears today in dominant discourse of media and politics is not seen as a problem of the economy or the society that produces homelessness; instead, it is viewed as the problem that the homeless create for the economy and the society in which they live” (Kawash, 1998, p. 320). Instead of taking up how to dismantle systems of oppression, the media courts debate through feel good stories of people who have been given the generous opportunity (through the nation-state), to ‘pick themselves up by their bootstraps’ and carve a possible life within systems of oppression. Our stories allow for the ‘good guys’ to debate with the ‘bad guys’ about how to resolve us.

Through stories that peers and participants tell to the media, we learn who we are as a nation. We learn that the nation is divided along simple binaries of us as either the deserving or undeserving poor. Press generated from these stories as told through the device of the At Home/Chez Soi project generate communal reflection on our politics, history, and social policy, and debate is accrued. In the age of digital media, exploring the comments sections that follow such stories offer a snapshot of where we stand on the topic of the homeless mentally ill as a nation. What follows are some comments generated from online article postings about the At Home/Chez Soi project. On the one hand, you have the ‘good guys’ who take aim at current government policies: “This is a moral issue as much as anything for the neoliberals and neo-tory voters. They just can’t wrap their blunted skulls around ‘giving’ anything to those so much less fortunate than themselves” (Culbert, April 8 2014).

Such stories also work paradoxically to depict the current Conservative government as progressive, especially since that same government has refused to invest in a national housing
strategy: “This is marvelous news. I can’t believe that the Harper government is actually looking at evidence for once and shifting money to this program” (Picard, April 8 2014). Yet others understand the project as political spin: “cons doing the chameleon image makeover thing again. They’re not fooling anyone. Just another con” (CBC.ca). One commenter uses the experience of a project participant to support the project, the MHCC and Housing First: “My friend Hercules is one of the individuals helped by this program so on the basis of the great help it has been to him I can only hope that the end result of the Commission’s report today is that more housing will be made to those who most need it, without the requirement of having to prove that ‘housing first’ is the best strategy! Emphatically it is!” (Picard, April 8 2014). In this way, our stories as feel good stories allow the ‘good guys’ “to reproduce its sense of goodness in the forms that are legitimately prescribed within a particular national formation, bonding with its compatriots and reproducing the nation’s mores and values along with, and as intrinsic to, the subject’s own individualized humanity” (Thobani, 2007, p.10).

Others make the issue about public safety, speaking of the project as good incentive to help “YOUR house and CAR probably getting broken into less. In other words either by taxes or out of pocket expenses you and I will pay for the social ills of this world” (Culbert, April 8 2014). Similarly, in order to secure public space, socio-medical interventions are justified: “I no longer go downtown to avoid the approach of so many lunatic panhandlers and drug addicts many who remove clothes right out on the sidewalk to inject themselves in broad daylight. Many if not most secure housing monitored by medical personnel who administer meds as required” (Culbert, April 8 2014). The ‘bad guys’ denigrate us as individuals: writing that “there are two types of homeless. 1. Those that wont [sic] work 2. Those that have addiction or mental illness. Money cant [sic] save them … Put them on an island so they can get off their addictions” (Candice Bergen, March 11 2014). One laments, “if only we could put the homeless in kennels” (Culbert,
June 27 2014), while another brings it back to neoliberal self-governance: “This study is all well and good but it ignores the simple fact that by providing this housing for free it leaves little incentive for the layabouts to get a job and support themselves instead of taking the easy way out” (Culbert, April 8 2014). Our stories are consumed for wider public debate, to be used in ongoing negotiations in securing a national identity which rests on Canada as a civilized, humanitarian nation that takes care of marginalized bodies that are willing to make efforts to civilize ourselves.

This is how our individual stories get turned into wider national narratives. And so we and others govern our narratives in the hopes of re-solidifying liberal perspectives of us, and changing the minds of those that are still against us. Peer stories of tragedy and recovery are used to sway public perceptions of us towards those of redeemable investments. Those of us still marginalized depend on such perceptions in order to keep our housing and other system benefits intact. Our lives depend on being understood as redeemable subjects worthy of pity and investment. As I have shown, we actively learn to mediate our stories in order to reduce risk, and these stories turn into national narratives that move us beyond ‘at risk and risky’ subjects back into the realm of humanization. This is why peer stories are so valuable: through peer participation, we are ‘back to work.’ Those who are chosen to represent the project in the media are those that tell the story of being back to school, back to work, or in the least giving back to their community through volunteerism.

In this way, our mediated recovery stories and recovered selves as peer workers help to incorporate us as mobile subjects and back into civility. As subjects always in process of becoming, whereas we were once positioned as stranger or outsider subjects, through our accounts of re/integration and normalization, we can become civil and even exalted subjects.
Peer stories of recovery and rehabilitation (especially into the workforce) offer us a make-over: communicating modest longings for ‘a home, a job, and a friend,’ as the recovery model is premised on, are relatable desires and “the embodiment of the quintessential characteristics of the nation and the personification of its values, ethics, and civilization mores” (Thobani, 2007, p.3). Both we who speak as recovered, and those that position as our allies, are imbued with a sense of moral virtue as our stories help stich us back into the moral fibre through possible participation in an advanced liberal democracy.

6.6 Conclusion

In this chapter, I have shown that peer storytelling is much more than simply a recounting of experiences. Peer stories shape how we build subjectivity and identity, how others make sense of us, and allow us to cultivate and solidify us as ‘people with lived experience.’ Further, as peer workers, storytelling is central to the work that we do. Currently, our storytelling is shaped by ‘recovery narratives,’ discursive fields that position us as bodies that are able to recover from abjection and work us towards ‘becoming human,’ with help from psy disciplines and social supports. Drawing on my own and other workers experiences of storytelling as peers, I show that we recognize such work as governed: constrained by dominant understandings of ‘the chronically homeless mentally ill,’ we mediate our stories depending on context, and we are concerned by what such stories help construct, as well as in whose interest such stories are told.

I argue that our stories, as amalgamated within larger regimes of truth, are crucial devices used as evidence that abject populations such as the ‘chronically homeless mentally ill’ are recoverable bodies. Such narratives work to build Canada as a country which is willing to invest in interventions to help render us as possible citizens. Narratives of us as recoverable are contested, as ‘mixed messages’ that are working together with conflicting and competing
narratives of us as biologically degenerate and the underserving poor. Taken together, these narratives open up public debate as to whether we are a nation that believes that all bodies are redeemable, or rather, whether such figures should be ‘let to die.’ Thus, our stories are harnessed in ways which ultimately ask of us who we are as a nation, and how far we are willing to extend ourselves in order to maintain understand ourselves as a white civil society based on founding principles of humanitarianism, equal opportunity, and as one which offers a wide social safety net.

In the following chapter, I turn to focus specifically on the work that we undertook as peers working for the project: I show how peer work was largely understood as successful when we were working in endeavors which governed project participants and other peers, and that we were less successful when working at tasks oriented at governing professional and structural practices. I argue that this is largely the result of how our knowledge is conceived: our ‘expertise by experience’ is taken up as beneficial to those ‘like us,’ and thus in practice our knowledge is used in antidotal ways that can help to inform how to negotiate the ‘chronically homeless mentally ill.’ Where our knowledge is less successful is when we try to intervene on larger systems of power: our knowledge fails to be rendered conceptually useful to govern prevailing regimes of truth and practices that constitute professional mental health research and service systems. Thus the paradox of peer work: relegated to improving the ways that the homeless mentally ill are governed, yet constrained when challenging professional and structural regimes of ruling.
Chapter 6
The Peer Paradox: The Mind/Body Split

7.1 Introduction

In Chapter 4, I showed how adopting a peer identity means that peers need to actively perform and represent in complicated, conflicting and contested ways. In particular, how we have to embody both as respectable and degenerate enough to read as authentically peer. In Chapter 5, I explored how storytelling as an exercise is foundational to both the re/construction of peer identity, as well as central to the work that we do as peer workers. Specifically, how the telling of particular recovery-oriented and embodied stories are central to peer work and the value that we bring to the assemblage. In this chapter, I expand my discussion of peer work to detail some of the other forms of labour that peers did for the At Home/Chez Soi project.

Specifically, I show how the forms of knowledge that we are expected to bring to peer work is anchored in experiential and embodied knowledge. Thus, when we move to articulate knowledge bases understood as conceptual and analytic, even when that knowledge is derived from ‘lived experience,’ we encounter trouble. Mainly, we create discord when we cross the boundaries of the experiential and destabilize the project of governing those like ourselves. Peers do bridge work in both professional and marginalized realms: we work with mental health professionals to enable access to populations understood as degenerate and we work with marginalized people to enable their access to the benefits of respectability. Ultimately, this is a chapter that tells the story of how we are organized. It is a story of how peer workers, when brought into the fold as part of an assemblage, can create small ruptures and reorientations in the project. Yet in the end, we are brought in to contribute personal experience as a form of expertise, a contribution that
allows for the predetermined work that both the project and the MHCC more broadly has already set out to do: the work of managing marginalized peoples on the State’s behalf.

Cartesian notions of a mind/body split underpin what in this chapter I term the peer paradox. Peers are expected to bring embodied knowledge to their work. Peers may offer ‘instinctive’ recovery-oriented support to each other and to project participants. Yet when we direct our knowledge towards organizations to change structural practices beyond the purview of governing ‘the chronically homeless mentally ill,’ our knowledge is troubled. In this chapter I explore how peers negotiate this paradox. I explore the limits of advisory and consultation work as a technology of inclusion, and document the flexibility required when a central condition of peer work is to speak to normalcy from a place of embodied abjection, and to adapt to an organizational culture of white civility. I document the development of peer-only groups within the project, and discuss the possibilities, limits, and conditions of acting in a peer advisory capacity to the project. The rest of the chapter, influenced by both Ahmed’s (2012) *On Being Included: Racism and diversity in institutional life* and institutional ethnography, maps the production of three peer-written texts by the National Consumer Panel, a national peer-only panel that I helped develop as part of my role as consumer research consultant. Here, I show that when we move to offer analyses which critique the prevailing hegemonic epistemes of the project, we encounter trouble. That is, when peers move to position ourselves as thinkers rather than doers, as mind rather than body, our knowledge must be managed because it risks undermining organizational authority. I explore the motivations behind writing the texts, the process and content of them, the ways in which they were organizationally-mediated, and once finalized, how they moved (or did not move) within the project as well the MHCC more broadly.
By doing so, I map some of the conditions of what can be produced textually by peers within organizational constraints: specifically, as peers, we learn to write about trouble without getting into organizational trouble. I show how these texts got used in practice: influencing procedural change, as a source of pride, and constructing peers as a site of productivity within organizational performance culture. I also show what gets left behind: text that is interrupted, disregarded, makes no impact, is organizationally contained, and meets a dead end. By detailing what work gets taken up, I show how peer knowledge that is practical, practice-based and conceived as generated through ‘lived experience’ is useful to the assemblage when such knowledge is directed at helping to govern ‘the chronically homeless mentally ill.’ Yet peer work that is analytical, critical, and is directed at unsettling regimes of truth and thus risks significantly undermining the project, is troubled and managed. And thus a central condition of peer work is participating in the project without significantly disrupting it, and to make small inroads we must adopt strategies of moving our knowledge forward in ways that mark trouble without becoming troublemakers.

7.2 Peer Knowledge and the Mind/Body Paradox

Epistemological models of knowledge continue to work in ways that separate lived experience, that which we know through embodiment, and acquired official knowledge, that which we access through means such as formal education and professional training. These binaries are at work when we enter peer roles. Mad peoples knowledge has largely been subjugated and dismissed. Through a Cartesian lens, mad people are irrational, and without the capacity to govern themselves. For instance, through the lens of Cartesian models of knowledge, both our mind and embodied knowledge is disparaged: that is, a condition of madness is that our minds are unreasonable, and further our embodied experiences are disputed, given that are tainted by
our unreasonable interpretations. Thus, the recent turn to value and validate the lived experiences of madness is a markedly new development and holds many possibilities. Yet, what does this move us towards? Here, I argue that because systems of knowledge continue to be demarcated through mind/body binaries, by basing our claims through lived experience, we make moves which value our embodied experiences, yet often in practice fail to recognize how such experiences can offer not only personal antidotal knowledge, but also deeply analytical, conceptual, and abstract knowledge. Thus, in practice as peer workers, our knowledge is harnessed as body, and not mind. That is, our embodied knowledge is valued, yet when we make moves to cross the imagined boundary into analytic knowledge, we meet resistance. Indeed, to recognize our minds would mean having to interrogate the foundation principle that mental illness is a problem of our minds (or more precisely, our brains). Herein lies a peer paradox: by pinning peer work to experience, it reduces our knowledge’s to the ‘body’ and makes using our ‘minds’ (our conceptual, analytic, and theoretical knowledge) difficult when we join into systems of power.

To put forward the idea that peer workers are expected to forefront our own lived experience to lead the work that we do is not novel. As I have shown, this principle is the main tactic that we have used in order to gain entry into systems of power. But when lived experience is understood as body knowledge rather than mind knowledge, it limits the work that we can do. What does it do when we make our way into the fold premised on the notion that the peer body holds particular kinds of knowledge that is different and inaccessible by other professionals already imbedded in the fields? That is, regardless of our professional and acquired knowledge, what sets us apart from other professionals as peer workers is precisely our embodied knowledge, and that is what we are brought in to use. How does trapping our purpose in the assemblage as embodied knowledge pin us to particular forms of experiential knowledge, and exclude understandings of
us as holding and making use of other epistemes? Further, how does pinning us as ‘experts by experience’ prevent us from contributing to other forms of labour that can work to dismantle rather than further entrench prevailing systems of ruling? In essence, I show how tacking our knowledge to embodied experience (body/emotion/speaking/feeling), it foreclose possibilities for us to position our knowledge as thinkers (mind/reason/conceptual/analytic). When we are brought in to represent experience, old Cartesian mind/body epistemological splits replicate.

To help contextualize how categories of knowledge get graphed onto particular types of bodies, I draw on Mohanram’s *Black Body: Women, Colonialism, and Space* (1999), in which she offers an intervention on Lévi-Strauss’ notions of categories of knowledge in “The Science of the Concrete” (1966). In Lévi-Strauss’ work, he makes an account of different categories of knowledge: on the one hand, there is native knowledge, the knowledge of the bricoleur, the Jack of all trades who is guided by instinct. On the other hand is conceptual knowledge, possessed by the engineer, knowledge derived from science. Mohanram points to the racial hierarchy that is embedded in these concepts. In this construction of bodies of knowledge in binary opposition, bricoleurs are positioned as inventive: they use whatever is at hand in their natural environments to make use of their ways of seeing, knowing and classifying knowledge, and thus their epistemological frames are closely influenced by their natural environment. On the other hand, engineers’ systems of knowledge, classification and scientific thought are positioned as removed from the natural world and rather located in metropolitan modernity. Such a removal “results in the production of different forms of knowledge. In terms of locale, the metropolis functions as the binary opposite of the ‘natural’ environment” (Mohanram, 1999, pp. 8-9). Thus, it is not bodies innately, but rather bodies in space that produce particular forms of knowledge: the engineer uses abstract thoughts, concepts and scientific knowledge “that moves them beyond their direct environment, and able to tackle concepts beyond what is materially evident
In contrast, the bricoleur is tied to his body and his land in order to make meaning: “the bricoleur works within the science of the concrete, the engineer within the science of the abstract” (Mohanram, 1999, p. 8). The bricoleur holds embodied knowledge related to spatial environments of the natural world, the engineer is able to disentangle themselves from physicality altogether. As Mohanram argues, whiteness is the capacity to move; blackness is static.

Mohanram intervenes on this formulation to show what binary conceptions of cartographies of knowledge produce:

> What is evident in Lévi-Strauss’ comparison of the bricoleur and the engineer is not that one categorizes and the other does not, but rather that the basis for categorization is different. One has intuition … to guide him; the other scientific proof. The bricoleur is able to make connections between the resemblances and make meaning materialize from possibilities. The engineer is seen as a more advanced model in that he forces the materialization of meanings from concepts which do not resemble each other in the first place. (Mohanram, 1999, p. 9, italics mine)

Thus, rather than drawing on customary overt racial thinking to demarcate bodies (such as some born primeval, others advanced), Lévi-Strauss focuses on how relationships with nature change the ways in which bodies are able to make meaning. Within this binary, the bricoleur’s classificatory relationship with nature and instinct is positioned as pre-capitalistic, while the engineer’s knowledge is located within modernity and capitalism (Mohanram, 1999, p. 11). As Mohanram notes, “the difference between the bricoleur and the engineer starts functioning within a discourse of development rather than one of difference – the bricoleur’s intuitive knowledge and mythological thought is primitive in comparison to the engineer’s ability to think in the abstract” (Mohanram, 1999, p. 9).
While Mohanram’s uses her intervention on Lévi-Strauss’ work specifically to map how racial constructs of blackness get tied to “webs of nature” and whiteness as universally free of it, Lévi-Strauss’ concept of bricoleurs and engineers is also useful to think through the paradox of peer knowledge when it is put to work, as well as how it is contrasted with professional knowledge. Throughout my own research, the binaries of ‘peer’ and ‘professional’ have been at play, each typology conceptualized as holding particular forms of knowledge. Similar to (but not the same as) the bricoleur, peer epistemology is pinned to raw experience that is mainly understood as useful when used in moments to govern ourselves and those like us. When we enter into a contract to become peers and do peer work, the central expectation is that we will draw from our own lived experiences as well as the knowledge derived from a universalized peer collectivity.

Peer work pins our knowledge base as experiential and embodied: we are ‘experts by experience.’ In At Home/Chez Soi, the spatial experiences of homelessness, knowledge of the cultures and cartographies of street life, experiential knowledge of psychiatric interventions and systems, and also experiences of distress are pinned to the mind, and sometimes to our other particular embodiments (of race, class, gender, culture, sexuality) as they converge. We are expected in our work to make use of such experience as knowledge, to make use of what is naturally at hand. Thus, our knowledge base is conceptualized as instinct.

In contrast, those occupying professional positions (researchers, site coordinators, clinical team leads and mental health/social/housing service providers) are largely able to disembodily themselves from their professional expertise to move forward in their work. Similar to engineers, their analytic, scientific and conceptual knowledges as official knowledge are the entry points that allow them into the assemblage, and expertise is usually not tied to their embodiment. Their conceptual expertise is supposed to enable them to transcend the limits of the body. Their particular forms of knowledge are not dependent on their environments, their embodiment, their
experiential knowledge: it is their knowledge as abstracted and impartial that positions them in similar ways to Lévi-Strauss’ configurations of the engineer. Professional knowledge is the science of the concrete, which “de-materializes and de-biologizes the body, and unhinges it from a specific place” (Mohanram, 1999, p. 16).

These constructed binaries of bodies and knowledge fail to contain us: there is always slippage, and such dualities as applied not only to our embodiment but also to our knowledge base never hold in practice. For instance, there are always professionals who hold ‘lived experience:’ still, their primary entry point into the assemblage is based on their official expertise, not their embodied knowledge. There are also workers who use both embodied experiential knowledge and professional expertise who are brought into the fold: for instance, Aboriginal health workers who are to draw on embodiment, experience, culture as well as professional forms of expertise. And peers themselves, of course, are never confined to the box of experiential knowledge. But as I will show in this chapter, there is an ease in which peers can do and are understood as doing ‘meaningful work’ when drawing on knowledge through the ‘science of experience.’ Yet, when we make moves to use our knowledge in analytic ways, that is, when we refuse to be bricoleurs and try to become engineers, this throws up tensions that then need to be managed.

7.3 Precarious Labour: Working Within Neoliberalism

Most of my job as a consumer research consultant was spent working with professionals and peer workers. While I did some work with project participants, a vast majority of my time was spent sitting as a peer representative on project committees (including the national operations team, two national research teams, and a national working group). In this role, I worked to represent the peer perspective and peer/project participant interests in the running of the demonstration project itself, as well as in research and housing/service deliveries. I was
absolutely understood as having both experiential and analytic knowledge: indeed, my subject position as PhD student allowed me entry into the higher strata of project management. Yet, very early on I realized that my professional knowledge (as critical theory) would not be used or be recognized as useful in this position. Rather, much of my work was to act as a peer informant to professionals, bringing considerations from a peer perspective to the decisions being made by project leaders. This was embodied and spatial work: most of it involved me embodying degeneracy and bringing it into spaces of respectability. It was at times rewarding work; sometimes awkward; often painful. Sometimes my perspectives and requests were taken up; sometimes they were not.

Many other peers integrated into professional committees in advisory roles, sitting on national groups as well as local research, service, and operations teams. It was very clear at the beginning of this work that the foundational structure of the research project were unnegotiable, and as I moved through the project I came to learn what was moveable, and what wasn’t. This was not unique to my peer position: all of those working for the project were working with particular constraints and demands that we had little control over: the constrains and demands of all levels of government; funder constraints and demands; community constraints and demands; stakeholder constrains and demands; organizational constraints and demands; and of course the demands of the research design and requirements.

Those leading the project were under considerable pressure to produce the outcomes that the project proposal set out implement, evaluate, and produce evidence on. This is without a doubt the most demanding pragmatic research trail that many had every worked on, and certainly the most complex, contested, and impactful: the project directly changed the lives of some homeless people, with the possibility of significantly restructuring future homeless and mental health
policies and practices. Coordinating a project of this magnitude produces risks: and I came to learn to honour the personal and professional risks that some of those leading the project undertook. A level of structural violence rippled through the project: the pace, expectations, and demands of those leading and coordinating the project at national and local levels was constant and unwavering. I was shielded from most of that violence: whether the project succeeded or failed in meeting the extraordinary demands of evidence-based research projects in the face of neoliberal demands of austerity, efficiency and efficacy went beyond my immediate concern. For those at the helm, it was of unrelenting concern. I hold much respect for those navigating this difficult personal and professional terrain.

There was also, of course, the everyday interactive, systemic, and structural violence that permeated the lives of project participants and those working with them: risk, poverty, terminal illness, histories and present day moments of physical and sexual violence, and death: the slow death that comes from bodies that have been left to die, but also extraordinary deaths, including homicides. The violence graphed onto the bodies of the participants – as Indigenous, racialized, disabled, gender and sexually variant, systemically impoverished, and as dispossessed – did not relinquish in weight once some of them were housed. By the end of the project, a reported 76 participant had died among 2, 255 study participants, keeping in mind that those are only 76 people that the project knew of who died: tracking participant deaths in the treatment as usual group would be nearly impossible (Silva, Bourque, Goering, Hahlweg, Stergiopoulos, Streiner & Voronka, 2014, p. 3). A profound amount of death, sexual and physical assault, loss, pain, and longing wove throughout the workings of the project, and funerals were frequent. The profound loss that some project participants and professionals were constantly confronted with worked in consortium and clashed against the demands of the project proper: to keep collecting quantifying and processing data. There were rarely ever moments for any of us to untangle the pain.
7.3.1 All Roads Lead to Peer Support Work

The peer workers that I interviewed occupied a variety of roles, including peer support worker, peer researcher, peer facilitator, peer advisor, and peer organizer. The employment roles ranged drastically: those employed as peer support workers had the most secure positions, with often full-time, unionized work with benefits. A majority of other roles were part-time contractually based, some salaried, while others were honorarium-based payments either for hours worked, or a predetermined set monthly honorarium. Anne, as one of the marginally-positioned and paid peer workers, noted, “there’s no job security, there’s no benefits. I’m recently just starting in this and I don’t have a permanent job or position anywhere but that’s what I really need.” She noted how using peer identity as an entry point into employment is new, and that “everybody like myself is involved in a couple of different little projects. And so that’s maybe the nature of modern workforces and modern life and whatever, but it’s almost like we need a union.”

As casualized labour, peers have difficulty entering professional fields. Peer support is the most professionally recognized and organized work that a peer can do: systems are able to understand our roles as peer support workers in supporting others in their wellbeing because ‘we’ve been there.’ Although such support work is naturalized and assumed as innate to our condition, as detailed in chapter 3, peer support work as a field of expertise is gaining momentum. It is a well-researched practice, with training and a developing evidence base behind it. Indeed, Canada is in the process of developing standardization and certification of the field. Those that I interviewed spoke with the most confidence and clarity about peer support as a legitimate field of work. It is work that draws on the ‘science of experience,’ knowledge conceptualized as embodied and as innate to our condition as peers. Yet paradoxically, peer support work is now becoming scientific, a regulated field with competencies and certification. Many peer support workers have
formalized training, and many had experiences of transitioning into formalized peer support work positions by being a part of informal (unpaid) peer support groups. As Ken notes:

I came into peer work, as many Mad and consumer/survivors do, through informal peer support groups, so through a student group initially, one that was based on peer support and advocacy… It was almost, it was very soon after I had gotten out of the hospital and so it’s kind of jumped me into the consumer/survivor movement and then from there I eventually gained a position at a consumer/survivor mental health agency, where I did more formalized peer support, and other types of mental health work, in the community drop-in setting.

Peer support work was understood as a field that offered opportunity and security: it was work that was well worth adopting a peer identity for. Those in such work felt that peer support work will only expand in future. As Paul noted: “I think that we’ll see in the future, if we can get recognized as a profession at the level of the Ministry of Health, me, I think that it will go boom!”

A constant problem that arose during my research was the lack of clarity in work roles for peers. Many of those interviewed spoke of being hired without clarity of what their work tasks involved, and even if they did have job descriptions, their actual work ended up falling largely outside of their mandated duties. There is a gap between knowing that peers must be involved in all aspects of a project, and conceptualizing what it is exactly that peers should do. The inclusion imperative often posed a conundrum for professionals, and the recruitment process in the project often meant harnessing peers first, and figuring out what to do with them later. Certainly, at the outset of the project, peers were recruited in order to amass bodies, rather than minds. Bob spoke of how he felt that he was given a job because ‘peer’ was one the boxes that needed to be checked, so when “they brought me in and there was no clear idea about what it was that I was supposed to do in my peer role.” This was even the case with peer support work, despite the fact
that as a paraprofessional field it has developed extensive working definitions, training, and boundaries.

Rachel’s experience of being a peer support worker for the project well illustrates this ‘knowledge gap.’ She had done peer support work in the past, and also had a graduate degree. After receiving her degree, she worked as a peer support worker on a service team, and describes that experience as leading her “to believe that the people who wrote the job description and were creating the team were not entirely sure what they wanted in a peer and how this person was going to be different from everybody else.” In practice, she ended up doing similar work that other service team members were doing, including involuntarily committing clients into hospital against their will and doling out medication: “I’m engaged as a peer taking people their medication, including people who maybe don’t want to take their medication.” Importantly, Rachel spoke about how in essence she was performing the same work that other professionals on her team were involved in, but for less pay: “I’m not in a social worker role, I’m not being paid as a social worker, I’m not a member of the social workers union or association … I didn’t come here to work as an underpaid social worker … I wanted that kind of [peer] job and I wanted that kind of experience, so I did it. But I really took issue with the fact that I didn’t know ahead of time that I would be doing the same as everybody else for less pay.” Despite holding a graduate degree, Rachel’s entry into a peer support position resulted in her being paid less than those with equal education. In this way, peer roles as underpaid positions work within neoliberalism’s task in fracturing professional fields and replacing such labour with deregulated workers that will do the same work for less. Thus peer work is a threat: it threatens already established professional fields by flooding the mental health field with paraprofessionals who are able to produce the same work at less cost.
Rachel’s experience of peer work also exemplifies how peer support work acts as a form of governance. The work involves governing ‘similar others’ behaviour with an end goal of securing recoverable and responsible selves. As a tactic, peer support work asks those from ‘similar communities’ to monitor and help make well ‘our own kind.’ Peers as governing agents bring what appears to be a softer touch to the work of disciplining unruly bodies. We enter into the relationship exchange with clients as model archetypes of how self-governance can lead to redeeming lives. Our point of contact remains shared experience, rather than scientific expertise, and it is through commonality that we are supposed to tackle resistant bodies. Rachel reflects on this dynamic found in peer support work:

I was just there to do what people needed me to do and one of the things that I find so difficult about this profession is that I feel as though I’m expected to be somebody’s parent, a grown person’s parent. And I don’t want to be anybody’s parent. I don’t like telling people what to do. I don’t like the idea that somebody doesn’t have enough insight to figure it out for themselves, and I don’t like the idea that I have better ideas of what they should be doing with their time than they do.

This tactic of regulating people through concepts of mutual experience also often fails: there were many moments within my peer role when both peers and participants told me to back up and fuck off. Those on the receiving end of support are often aware that the precarious principles of ‘mutual aid and understanding’ are being used as new management strategies to govern bodies.

Those involved in peer support work can be aware of this too. Ken accepts this role, noting that as a peer “we’re always gatekeepers. And that’s some of the issue with progressive politics, right? Is that people think that they’re not sometimes, when in most situations, if you have any amount of power, you are. So get over yourself, right?” Others grappled more with the regulatory powers that are tied to the peer support worker role. Rachel here speaks of her own ‘recovery
rebellion,’ of adopting resistant strategies to subvert the expectations of peer support workers as governing agents:

Everyone was obsessed with recovery and obsessed with goals and I didn’t want to be doing that and so sometimes I didn’t … If somebody was on my back coming to my house once a week saying, ‘well, did you sign up yet, did you take a course, have you cooked anything, did you get a bicycle’ it would make me angry. And I think there was a lot of that going on and I think that a lot of the time I just wouldn’t ask those questions and that was my little mini act of rebellion, was just not asking people whether they signed up for the library yet … Because their goal was to survive. Their goal was not to die.

It is often assumed that peers are inherently and naturally peer support workers, equipped through experience to support others experiencing distress. I experienced this throughout my work: even though I was hired as a ‘consumer research consultant,’ and expected that my role would be in research, in practice my role largely became organizing and supporting other peers in both their work and life. The recovery rhetoric of hope, optimism and compassion are now affects that peer workers are supposed to embody. Despite my ‘lived experience,’ an optimistic care approach is not intrinsic to me. I had to learn compassion, empathy, and support work in order to properly embody peer. While hope and optimism as recovery tools still elude me, I learned to instead harness my cynicism and sarcasm to relate to others with lived experience. I worked to establish relationships with other peer workers based on suspicion: about the limitations of our roles, critique of professional practice, systems, and structures that we were working within, and sharing the pain of everyday worklife, which often worked to build bridges between us. My character transformed into a tactic: a tool to engage.

Other interviewees also spoke of how all peer roles eventually lead them down the road to peer support work. Despite not being in a peer support work position, Jackson spoke of how that ended up being primary work: “90% of what we did, was fucking peer support.” Lee spoke of
the similar experience of having to perform peer support work despite the fact that this was not her work role:

My duties weren’t necessarily to provide support in personal things every day … That wasn’t in my job description. But I have to do that … It actually turned out to be calls. Like right now there is somebody in tears on the phone that I have to get to. But it’s more home life. It’s more about housing. It’s more about going to court with someone. It’s more about all the support that was not in my duties … So one of the things, I guess, that could be maybe a finding is that when peers are hired they’re hired to do – like as peer organizers, they’re hired to do these administrative organizational tasks. But what gets excluded from the job description, and where the actual work lies is doing more formalized peer support work. And that’s a big issue because they were looking for a part-time person for this position. And with all the [invisible] work it is fulltime.

Thus, both people with lived experience and professionals alike expected those of us in peer roles to perform peer support, regardless of what our actual job descriptions were.

 Nonetheless, the ‘peer support worker’ as a paraprofessional role was work that caused the least amount of confusion to the project. Peers as support workers make sense, in that we are using our experiential knowledge to help manage the ‘chronically homeless mentally ill.’ One of the peer-written documents that developed out of the project was the “Peer Support Workers Communities of Practice Discipline Summary.” Written by the Peer Support Worker Communities of Practice, a national group made up of At Home/Chez Soi peer support workers, the purpose of the document was multilayered. It generated initially out of a reaction to the ways in which the project had already described peer support work in previous documents: in particular, how it was inferred that peer support workers must have lived experience of severe mental illness and should be ‘in the process of his/her own recovery.’ This connotes that peer support workers should not be experiencing active distress/madness when practicing in the field. This mattered to some peer support workers, because it creates a divide: between those who had experienced past distress but no longer did, versus those that experience ongoing distress. In
essence, it implies that only those that have learned how to ‘actively manage and suppress’ their madness should be working as peer support workers, and that those in distress should not be practicing. In effect, one condition of working as peer is that we should no longer be actively mad.

As a result, the Peer Support Worker Community of Practice generated the “Peer Support Workers Communities of Practice Discipline Summary,” which works to set out a clear definition of peer support work, core values and principles of the field of practice, as well as skills and approaches to practices that peer support workers bring to the mental health field. Partially, this document was motivated as a response to the uncertainty and confusion over the role of peer support workers in the health and service systems field – peer support workers used this document as a way of creating clarity as to what peer support workers actually do, which in turn answers the questions professionals pose: we know we need include to peer bodies, but what do we do with them once we have them?

Importantly, the eleven page reader-friendly document also works to solidify peer support work as professional expertise. The purpose of the document is to “outline the guiding principles and philosophies that support our practice … It is also intended to provide various stakeholders with a framework for the specific skills that PSWs bring to mental health systems…” Our hope is this kind of document will begin the process of integrating more Peer Support Workers within the system” (PSW COP, N.D., p. 4). So at once the document is a reaction to how peer support and peer support workers are being conceptualized, as well as meant to redress conceptions that peer support workers must be on the journey to wellness. It works to offer precision and a clear summary of peer support work as a discipline, in order to clarify the role when peer support workers are recruited and employed. And finally it works to make actual peer support work as a
paraprofessionalizing field: it ‘disciplines’ peer support work by offering a clear set of values, principles, skills, and approaches that peer support workers bring to the health and service sector. In that way, the document works to solidify and reify, as a discipline summary, the discipline itself.

As Ken reflects, the Discipline Summary document “focused on very specific things that peer support workers did, background and approaches to practice, and was meant as a tool for people to use at the present, for managers to use at the present in working with peer support workers but also as a tool to develop other peer support worker positions, and I think it helped out … [the document] got some good coverage across the project.” When the PSW COP Discipline Summary was finalized, it was circulated to key stakeholders working on the At Home/Chez Soi project. While it was an internal document, in that it was never sanctioned by the MHCC, people were encouraged to circulate it to their circles outside of the project. The document had a lot of uptake: it was taken up and taken away, circulating to agencies and people that were already, or thinking about, employing peer support workers in their settings. I continue to send and circulate it as a starting point for people when they are in touch about integrating peers in their work settings. The document is practical: it answers questions, rather than raises them. It is non-threatening, uses bullet points and brief summaries to promote peer support work, and has a concrete set of clear take-aways that professional can use and apply. As a result, as a document the Discipline Summary aims to make more peer support work possible.

7.3.2 Peer Informants to Engage Degeneracy

Peers offer an expertise about the conditions of homelessness and mental illness that is often sorely needed. As explored in Chapter 4, peer subject positions act to bridge respectable and degenerate identities. We work hard to embody as both professional and authentic enough to
cross the divides between normalcy and degeneracy. The work that we do in peer roles follows these same binaries: peer work is bridge work. We are harnessed as peer informants both to help and inform the homeless mentally ill, as well as those professionals working with them. As peer informers, we act as embodied translators. A peer is a body both familiar enough to respectable and degenerate spaces, and is used to bridge between them. We translate professional knowledge policy and practice to marginalized bodies to help make sense of respectability: we clarify why things are the way they are, and how to work with, around, and outside of them. We also translate marginalized knowledge to professionals: we work to broaden understandings of the cultures of madness, poverty, and intersectional oppressions to a respectable citizenry who then may choose to apply this knowledge in policy and practice. Some peer workers work primarily with service users, and so their work is mainly focused on modelling, rehabilitating, and governing. Other peer workers work primarily with various health, social, and research professionals in order to inform them on peer perspectives. But these are never discreet audiences: there is always overlap. We are supposed to work both the recovery model into the subjectivities of the homeless mentally ill, as well as into the social fabric of structural systems.

As peer informants, some of the work that we do is use our knowledge of spaces and places to literally track participants who need to connect with professionals: for housing, treatment, or research follow-up. Recall that while half of the At Home/Chez Soi participants as the intervention group received Housing First housing and service provisions, the other thousand, as treatment as usual group, did not. This group of people, many of whom remained homeless throughout the two year research follow-up, were crucial for research teams to stay connected with in order to be able to provide a comparison group and an evidence and outcome base for Housing First programs. Doing outreach work to find homeless people so that they could do a research interview, and be paid an honorarium, was part of the work that some peers did.
Thus, some of the labour that peers performed involved drawing on community and spatial knowledge of where homeless people congregate and connect in order to find them. Norman recounts how he’s “lived in the target area where the participant populations are for the last 25 years so I know the area. I know the people.” He used this knowledge as a bridge to inform the At Home/Chez Soi staff where a participant may be located, noting how staff relies on his knowledge to “track someone down specifically because I know where most of them hang out. About 80%, I know their habits and hang outs and stuff like that. I know where to find them and even almost at the different particular time of day where they would be. Just tracking, you know, I’m not spying or nothing but I just know their favourite places and stuff. So I say ‘I think you can find Johnny over at [a drop in], he’s usually there between two and five,’ that kind of thing.”

Similarly, Veronica spoke of the spatial work that makes up peer work:

I find the people that are hard to find … So I go to the soup kitchens and they usually come in there, or the grocery stores or churches or open house dinners or [homeless organization] in case [they’re] looking for another rooming house or trying to get, you know, clothes … And that’s where I go because I know all the places and I go to those places, you know – sometimes to find whatever I need or whoever I need to find. And even right on the street sometimes, you know, like going for a walk because I know all the different times at night and if they’re out at night more than they are during the day. So that’s how I find the people that are hard to find.

Thus, as peer informants, we use our knowledge of the people and places that we have ties to or can easily access in order to generate and sustain connections with people in current states of homelessness and distress. Crucially, we harness our ‘peerness’ in order to make and sustain connections with participants. Veronica reflected on using her peer subject position to persuade potential At Home/Chez Soi participants to become part of the project. She spoke of how many homeless individuals weren’t volunteering for the project because they understood that one of the requirements to qualify was that they be mentally ill. Veronica spoke of how “they thought it
was for crazy people and they said they weren’t crazy and I said, ‘well, I’ve been crazy my whole life’ … so I could make them laugh. I said that I had mental health issues too and I got help and if it wasn’t for this one person that helped me, just like I am trying to help others, that I wouldn’t be here today. That I would probably still be living in the street or maybe dead.”

Through previous/sustained connections with communities, peers as informants use the rapport and trust established through their peer identity of commonality in order get work done. Veronica spoke of ‘word of mouth’ as a tacit used to find participants (who may or may not want to be found): “Yes and that’s another thing – word of mouth. Because I know the cousins or the sisters or the brothers or whatever, [and I ask] do you know where they’re at? Or do you know where I can find them? Or did they move? That’s how I usually find them, like word of mouth and they say ‘no they moved here or they moved there or they’ll be at the open house or, I just saw them the other day.’ … Sometimes it might take weeks, sometimes it takes hours, sometimes it takes 15 minutes.” Through putting these inquiries out into the community, participants often then get and stay in touch with the project, which allows for the intervention work to keep working.

Veronica spoke of peer work as bridge work by noting that peer work is a way of allowing participants to circumvent professionals yet still get resources, because “sometimes they don’t want to talk to those people.” We also work to mediate between professional and degenerate bodies: Veronica told the story of recruiting one participant who undertook the initial At Home/Chez Soi qualification assessment interview and was told by the researcher that he didn’t meet the requirements as a project participant. Veronica was incensed because she believed that he did, followed up with the participant, who told her that he didn’t trust the interviewer, “he just answered that way he thought he should” and wanted to get off the phone because he “thought
she was a woman from welfare.” Veronica followed through with both the researcher and the potential participant to bridge understandings on both sides so that the business of getting participants into the project would be a smoother process.

Peer work can never rely simply on ‘lived experience of mental illness/homelessness:’ it also always relies on other identity markers that in combination offer layers of sameness and difference that make particular peer workers more or less relatable to a particular participant. As Heyoka notes, “you need different personalities to serve the types of people we are trying to help. . . no one will suit everyone.” Veronica spoke about how she used her gender to both recruit and sustain women in the project: “some women had been traumatized and really didn’t want to be speaking to a man … and because I was going to be asking people to be in this project it was easier for a woman to ask than a man, especially asking the women to be in this project.” Others spoke about using their race, cultural, sexual and/or Indigenous identity in order to build relationships with participants. Diversity is made useful by peers as an agent to connect with diversity. Drawing on Ahmed’s work, while peers “already embody diversity by providing and institution of whiteness with colour,” (Ahmed, 2012, p. 4) we also make use of that diversity as a key component of our peer work: to connect with others constituted by difference.

7.3.3 Bending over Backwards: Consulting with professionals

Much has been said about the work that peers do with social and mental health service users. That is the work that much of the peer literature rests on: the difference that we can make in the lives of people like us. Instead, the rest of this chapter choses to focus on the work that we do as peer informants to educate, inform, and change the ways that respectability works with and on us – be it professionals and their fields, social and health policy, research methods and methodology, and/or everyday mental health and social service practice. That is, when we shift
the focus of our work away from ‘those like us’ towards those who are defined through rubrics of normalcy. As shown in Chapter 3, a substantive amount of scholarship has also contended with how peers collaborate with professionals, outcomes of that collaboration, and how to best plan for such collaboration in future (Rose, Barnes, Crawford, Omeni, MacDonald & Wilson, 2014). Again, here, I chose to sidestep offering a comprehensive account which measures the impacts of peer involvement in the At Home/Chez Soi project. That is a different project, one that is already being undertaken within the context of At Home/Chez Soi (van Draanen et al., 2013; Nelson et al., 2015). Instead, I want to mark here the contentions of consulting and advocating as peers to professional practices within the confines of a respectable organization.

All peers, whether working predominantly with participants, other peers, or professionals, had to negotiate difficult conversations with professionals about ‘the homeless mentally ill.’ In professional settings, the culture of the project necessitated discussions about ‘people like us’ as abstract populations abstracted from humanity. ‘We’ were talked about individually and collectively, sometimes as resilient and recoverable, and other times as troubled, resistant, and sometimes beyond resolve. I use here three ethnographic moments to illustrate the tension of trying to ‘work up’ to intervene on professional practice. The first, during a national research team meeting. I am surrounded by mostly quantitative research leads, and it is the first time that they have been able to quantify participant numbers and measures. They are excited. Participant information has been amassed, and is projected on a large screen. I see bodies broken down into numbers and categories: by gender, age, and diagnostic criteria; some in the intervention group, others in treatment as usual. It is overwhelming to see and feel these bodies reduced to numbers to be played with. I start to sweat, and grow silent. One researcher begins to talk about troubled participants who fall into one particular diagnostic criteria, and how they are unsuitable and unmanageable within the project intervention model. This is a diagnosis I received decades ago.
He argues that including those with this diagnosis in the project will skew the numbers outside of our favour: that the success rate of Housing First will diminish by including those with this diagnosis in the project. I sit and listen as the researcher discusses these participants, grouped together under this diagnosis: they (we) don’t respond well to the service interventions; they (we) need stricter guidelines; and service providers are unable and unwanting to develop relationships with them. Us.

I sit and let this conversation settle over me. I don’t speak. Eventually, I stand up, go to the washroom, and cry. I come back contained, shut down: sweating yet cold. As the full-day meeting comes to an end, I say something. I don’t say what I could say for many reasons. Partially, because I don’t want to put my own body - already always in jeopardy - on the table. Also, because, as critical antiracist feminists have already well-articulated in their insistence that it is not up to racialized people to educate white people on their racism, I don’t want it to be up to me to intervene. But of course, that is the role that I am in: to inform. I say, trying to evoke a neutral tone, that this has been a very difficult meeting. And that perhaps we should all reflect on why, as the only peer at the table, that I would find it so. They ask me to tell them why: I decline. In some ways, I failed to do the job that I was paid to do that day. I retreat to my luxurious hotel room, vomit, and via airplane, hobble my way home.

Moment number two. We are at a large qualitative research team meeting, and are actually going to engage with participant research transcripts. This is a rare moment in my everyday work life. We are put into smaller groups. I hear that someone engages with the interview transcripts by trying to decipher whether an event that a participant is recounting actually happened, or if it is psychosis speaking. Basically: they are working to figure out whether it counts as truth or discounted as symptomology. We rejoin as a larger group, and a junior researcher asks the
question: have we had a discussion about how we are methodologically (never theoretically) going to approach the data? I am pleased that this question has been asked. There is some bristling among the senior researchers. One responds, amused, that we haven’t had that discussion because it was assumed that we would all be using grounded theory. Is there any other kind? It is a moment in which I risk thinking out loud. I ask whether it isn’t a bit of a positivistic approach to the data, and perhaps there are also other ways of making use of them? I am met by a rather pointed reply by another researcher: “It is actually the very opposite of positivism, Jiji, as we are allowing the data to emerge and speak for itself. It is the opposite of positivism.” I have been informed, and have been put solidly back in my place. The data exists in the world, and we just objectively find it. My theoretical knowledge, withering, is not put to work.

Moment number three. It’s the end of a very long all-day meeting. I have my winter coat on, ready to go out into the evening. I’m sidelined by a professional who wants to discuss the situation of one peer working in his site. It is a question of accommodation. In essence, the professional engages me in an hour long conversation about how the peer is ‘pulling the wool over my eyes’ in their accommodation needs and requests. I am told of the great lengths that many professionals have gone to in order to meet the requests of this peer worker; that they have been ‘bending over backwards’ to accommodate the peer worker, with little result. The conversation is a litany of common tropes of disability being used to gain advantage: I am being informed that we are all being fooled. Again, I start to sweat profusely into the armpits of my coat; but I keep my coat on. I respond, engage, offer peer perspective. I am bending so far backwards trying to engage this conversation that I feel that my back might break trying to bridge this divide. It is an unsettled conversation: he works to convince me, I’m at once flexible and immovable. It is a forced friendly conversation. By the end of it I have perspired so heavily into my coat that I have to throw it out: it is the sweat particular to panic that is impossible to get
out once embedded in fabric. Bending over backwards into a bridge position becomes the visual I recall in difficult professional encounters. The more flexible I get in my mind, the more pain I experience in my body. Bending over backwards is recognized visible work that professionals do in order to accommodate peers: the bending over backwards that we constantly do in order to sustain working relationships with professionals remains invisible labour.

7.4 Peer-Only Groups: Learning Possibilities, Conditions, and Limits

Aside from consulting with professionals in my peer position, the other main work that I was responsible for was advocating, developing, and supporting peer-only groups across the project. The purpose of peer-only advisory groups to inform the project is key to peer participation: through the development of these groups as consultation bodies, an organization extends some power to those that collectively work to represent degeneracy. We advise, and make small shifts. Peer groups offer many things: it is good community-based and recovery-oriented practice, and it is good optics. When we extend Ahmed’s analysis of what ‘diversity’ does for organizations to include not only racialized bodies, but also disabled and poor bodies, we can understand peer workers and especially peer-only groups as offering good public relations. For the MHCC broadly, and in particular the At Home/Chez Soi project, bringing peer diversity into the project helped to counter and contain concern, critique and bad press that doing a clinical trial on homeless people can create. As Ahmed notes, bringing and showcasing diversity within institutions as public relations “is often what comes into force in a situation of crisis for an organization or, to extend the terms used in the definition of public relations, in situations of ‘bad will’ or ‘ill will’ … Diversity as public relations can thus be mobilized in defense of an organization and its reputation” (Ahmed, 2012, pp.143-144). As a response to ‘nothing about us without us,’ when peers are brought in and become embedded in organizational structure, the
without’ changes to ‘with,’ and the organization is able to proceed with us, and more importantly we become ‘with them.’ Peer-only groups offer good optics of community involvement and integration.

Not all research and service system enterprises have peer-only groups: while many will harness a few peer informants to help guide the workings of a given venture, having advisory groups that are peer-led and peer-only remains rare in practice. And when there are peer groups, often these assemblages are led by non-peer professionals as moderators, setting agendas and keep organizational control of the group. This was not the case with that At Home/Chez Soi project: commendably, and in some instances with reluctance, the importance of having official spaces and sites where those working as peers could collect, commiserate, and consult was recognized – and separate spaces were developed for and with us. Much of my early work was spent advocating for such spaces, and most of those sites that had not already planned for local advisory groups shifted budgets and procedures in order to make room for peer-only advisory groups. Nationally, the project had planned at the proposal stage for the development of a peer-only group, which was part of my work role to develop: this group became the National Consumer Panel (2009-2013), which was comprised of two national and two local peer workers from each site. There was significant budget planned at the front end of the project for the costs associated with this group, including travel and honorarium payments. We met monthly via teleconference with initial quarterly in-person meetings, which were reduced due to budget constraints (a budget I had no control over) towards the end of the project.

As the project progressed, other national peer-only groups developed: the Peer Support Workers Communities of Practice, who held monthly teleconferences to share peer support work practice issues; and the Peer Qualitative Research Group, a peer-only research group that I initiated (see
Voronka et al., 2014). There was flexibility in shifting funds in order to make peer-only groups possible at the national and local level. At the local sites, all but Moncton developed peer-only groups. Toronto was one site that had planned at the proposal stage to implement a peer-only group (budgeting to support was came to be the Toronto PWLE Caucus). Vancouver, Winnipeg, and Montreal shifted local budget funds to accommodate the need for peer-only groups. Much of my early work was advocating for peer involvement and peer-only groups: peer representation increased with the help of my early seat at the operations team table. The project invested a remarkable amount of money into peer-only groups.

Peer-only groups consulted, advocated, advised, complained, and created. We worked to manage and maintain each other as peer informants. We reviewed and advised on research, operations, and service provision: we made some things happen, prevented some other things from happening. We spoke: we told our stories, gave conference presentations, participated in Town Halls, were made and made ourselves visible. As peer facilitators to peer-only groups, some of our work was also about managing expectations. We all developed Terms of Reference that made clear that our work was to advise the project, nothing more. As Jackson notes, some of that front end group development work meant making clear that our power to shift things was limited: some peers in advisory roles “literally thought they had veto power: if they didn’t like it, it wouldn’t go. Meanwhile [peer advisors] are minutia, and the Commission is fucking 90 miles down the road.” In this way, peer consultations work to allow the work to get done. As Ahmed notes, the risk of consultation is that it helps legitimize the work to carry on: “when consultation becomes a routine, it does not mean organizations actually use it to change what they are doing … In other words, organizations can consult in order to say they have consulted.” Consultation can thus be a ‘technology of inclusion’ which legitimizes and authorizes the work within
particular communication constraints: “It involves a very particular line of address: between those who consult and those who are consulted” (Ahmed, 2012, p. 94).

The peers that I interviewed expressed mixed feelings about peer-only groups. Most felt that having such groups embedded within larger assemblies was crucial. Peers spoke of peer-only groups as ways of building community and solidarity within a project that otherwise left many feeling fractured. Lee spoke of peer-only groups as offering a space to feel comfortable, as well as a site of learning: “I learn a great deal [more] when I’m in a group of peers … than when I’m with one or two [as] a representative at a table. I learn more in a group of peers.” She spoke of how one peer-only group “was well put together. People were able to talk frankly about things. And be open and put it on the table and get issues resolved. And it wasn’t just having a meeting, doing minutes, coming back to a next meeting. There was a progression.” Bob spoke about one peer group as being “totally my best experience” and reflected that having to do with having a clear work role within the group: “that was the first time that I really felt included and valued and also kind of called upon. Like, this is what we want you to do and you have to do it. Whereas with all the other work there wasn’t much of that at all.” Others spoke of the solidarity that peer-only groups bring. They shift the dynamic of being ‘difference’ in normative assemblages: in peer-only groups, difference is normalized. Heyoka found that peer-only groups offered a sense of collegiality and community-building, such as during “break times when we got to interact with our peers from across the country … You know, the smoke breaks, that was the value that I got out of those.”

One peer expressed concerns over organizing groups based solely on identity difference. May noted that “while it’s not that I’m against the idea” of peer-only groups, “I can tell you that there is a danger in legislat ing segregated groups.” She draws on the experience of First Nations
organizing to note that “we’ve learned from experience that there’s a danger in having segregation.” May invokes a tension that exists whenever groups of difference develop exclusively based on identity or experience: with inclusion comes exclusion. While May’s concern was based more on concerns about what power is actually afforded to such groups, others within the organization at large argued that peer-only groups segregate bodies based on difference, and that this in itself is stigmatizing. That is, it is stigmatizing to organize and segregate bodies based on difference. This ignores the fact that structurally we are constantly segregated because of our difference. Further, organizational arguments against peer-only groups largely consisted of how the criteria of being a peer worker excluded others from belonging: in particular family members. Thus peer-only groups are not only critiqued on the premise that incorporating diversity across the organization is better (an infusion of diversity); but also because peer-only groups define subjects by their identity, and thus exclude others without it. Ahmed describes a similar tension when a people of colour only caucus was developed within organizational space: “Did giving the people of colour a space allow the event to stay white? The caucus was explicitly framed as a space for all participants of colour; whatever my caution, I was relieved to have the space when the time came; it can be tiring, all that whiteness” (Ahmed, 2012, p. 36). Despite concern from peers and the organization over what peer-only groups risk re/producing, most of those that I interviewed spoke of peer-only space as a place to provide respite from embodying diversity within their peer work roles.

While in theory most peers felt that peer-only groups were essential, in practice the 7 peer-only groups that developed throughout the course of the project were very different in organizational structure, mandate, and impact. Claire, addressing the limitations of one peer-only group, spoke of how it was “a little kiddie table off in the kitchen. It really wasn’t involved in the conversations and the communications and we didn’t have a mechanism or a process to really
have an impact on how things were run. You know, nobody really cared what we had to say, nobody asked us questions, nobody came to us for reference.” She spoke of how professionals and peers alike always spoke of avoiding tokenism: “we all said all along you know, ‘oh, well, we have to fight against tokenism’ and other people told us that too. One of the team leads said ‘you have to guard against tokenism.’” But the work of avoiding tokenism is placed as the work of individual peer workers, rather than as structurally embedded: she notes how professionals are the ones who have to “guard against us being a token by taking us seriously and coming to the consultations. It’s not our role to do that, but they didn’t.”

Many spoke of the possibilities of peer-only groups: Sally spoke of them as spaces where you can “gain solidarity from one another and reinforce your own experiences.” Rachel spoke of it being “important that people have a place to come together,” and for “people to have a place to be honest.” She notes that building effective peer-only groups is “hard to do, but if it’s done well I think it could be a really useful space for people. People need to be able to be honest about how they’re feeling and people need to not feel alone in the work that they’re doing. So I think that it’s worth protecting spaces like that.” Then, in assessing the development of one specific peer-only group, Rachel remembers “feeling as though it was an exercise in checking a box, like ‘we need to be more peer involved because we said we would be, so that’s what we’re going to do.’ I always got the impression that peers were an afterthought in this project as though somebody was like ‘wait you didn’t build this in’ … And so I never really got the sense that anything was going to be taken seriously on the [peer group], as though we were just being placated or something.” Although Rachel didn’t feel that peer-only groups developed as foundational to the project, she acknowledged that the project worked to incorporate peer involvement in an earnest way: “there was some really good intentions. Also I think that although overall I felt as though it was an afterthought, I also think that a lot of people really wanted it to exist and really wanted to
do something with it and really wanted to be able to have the peers give their feedback and also it was a place for us to all get together.” So while most peers spoke of peer-only groups as useful, they were also met with apprehension: as Bob wondered, “may times I thought, what the hell am I doing here, what are we doing? Are we making any impact? It was kinda weird.”

While a full story of what peer-only groups produced within the At Home/Chez Soi project is an elaborate one well beyond this scope of this chapter, I now turn to focus on three main documents that the National Consumer Panel produced during its tenure as the national peer advisory panel to the At Home/Chez Soi project. Through this mapping of how peer-written texts move through the organization, I elucidate some of the ways that peer texts are organizationally mediated. These texts mark moments, when as a peer collective, we make moves away from representing embodied speakers towards positioning our knowledge as conceptual and analytic, and thus ‘knowledge proper.’ That is, when we cross the binary divides from speaking to thinking subjects, it places pressure on the project. Drawing on and influenced by institutional ethnography (Smith, 2005c; Smith, 2006d), I narrow my focus to explore how three specific peer-written texts move through both the At Home/Chez Soi project and the MHCC more broadly: detailing peer motivations behind writing them, how drafts were institutionally mediated on, and how the final versions of these texts moved (or failed to move) through the project and organization, as well as out towards the realm of public access. As Ahmed notes, “we can ask what documents do by considering how they circulate within organizations, creating vertical and horizontal lines of communication. To ask what documents are doing, we need to follow them around (Ahmed, 2012, p. 85).” So rather than narrowly focusing only on a textual discourse analysis of what these peer-written documents say, I also focus on how these texts move through the project and the larger MHCC, and “follow them around, to explore what they do and do not do, when they are put into action” (Ahmed, 2012, p. 50).
7.4.1 Mediating Media Access: the National Consumer Panel Media Discussion Report

In the previous chapter, I showed how storytelling is key to peer work. Hearing stories of homelessness and madness from those who have experienced it work to, among other things, mobilize support for interventions work. Stories of hardship and recovery, especially when dispersed though media, feed conceptions of the self, the other, and of nation. They allow us to build, including the building of organizations. From the beginning, the project and in particular the MHCC Communications Department was clear that stories from people with lived experience were crucial to averting risk and generating goodwill for the research demonstration project. Our stories are commodities. When the project started, participant recruitment had yet to begin, those who were directly housed by the project were still inaccessible, and thus peer workers on the project were sought out to speak from lived experience on behalf of the project. Many peers during the first year of the project spoke to the media. Once project participants were recruited, while peers continued to be asked to speak of our experiences, the demand moved more heavily onto project participants, those whose lives had been directly affected by the At Home/Chez Soi intervention.

Many of the members of the National Consumer Panel were asked to speak to various media outlets, and most of us said yes. Some had positive experiences; some had negative experiences. Stemming from these media engagements, questions on the politics of representation in the media, and in particular the politics of asking both peers and participants to tell their stories in order to promote the project, were raised at the National Consumer Panel table. Questions about participant confidentiality arose: how could project participants remain anonymous if they were revealed in the media? The answer always was that it was participant choice to revoke anonymity by speaking to the media. Questions about the ethics of asking peer workers to reveal
their difficult experiences as part of their work role were too always answered as a question of choice. The choice paradigm “rests on essentially individualist, consumerist notions of ‘free’ choice that do not take into consideration all of the social, economic and political conditions that frame the so-called choices” that we are forced to make (Smith, 2005a, p. 127). The fact that choice is always limited and structurally-mediated, when raised in the context of the project, appeared to be either incomprehensible or disregarded by those working to push PWLE ‘out of the shadows and into the light.’

As the media demand for stories continued, early on in the project the NCP decided to invoke some questions, concerns, and considerations for the project professionals, peers, and participants to consider when speaking to the media by writing a report on media representation and disclosure, a document that was written for the operations team of the At Home/Chez Soi project. This was self-generated work: the project did not ask us to undertake this. Part of the freedom that we had with the NCP was that we were able to set our own work priorities, as well as react to what we were asked to consult on. This allowance for setting self-generated work outputs was crucial to the success of the group: rather than only being paid to respond to the project, we were also able to identify and set priorities.

What resulted was the “National Consumer Panel Media Discussion Report,” submitted to the national operations team early in the project, in May of 2010. This internal document worked to bring forward key issues about media representation for project consideration, and starts with a summation of key issues that asking people with lived experience to speak to the media evokes; it follows with considerations on self-disclosure and the media from an Indigenous perspective; and ends with a sample tipsheet condensing some tips, pros and cons in speaking to the media aimed specifically at project participants who are considering speaking to the press. One of our
recommendations was that this tipsheet prototype be made available to participants to read any time that they were approached by the project to speak to the media. Eventually, our tipsheet was turned into a media pamphlet to be shared with project participants.

In the executive summary of this report, we summarize the purpose of the document as follows:

The troubling ways in which persons with lived experience (PWLEs) of homelessness and/or mental health issues are represented in the media has been well documented (Anderson, 2003; Corrigan & Mathews, 2003). Often, media articles and news reports depict PWLE as violent, lazy, and objects of pity or scorn. The National Consumer Panel (NCP) is well aware of this fact and wants to ensure that participants in the At Home/Chez Soi project are not objects of this type of exploitation and stigmatization. The NCP has a number of recommendations, which include: the use of peers working on the project to act as direct media supports to participants in the event of media interviews, and the distribution of a tips, pro’s and con’s sheet to PWLE and participants before they speak to the media. The role of PWLE is also considered in this paper in terms of how it is that those working on the project will engage with the media, and what the role of media education will be. The NCP looks forward to creating a dialogue with the rest of the At Home/Chez Soi project to develop a media and communications strategy that will set the standard for how organizations involved in the field of mental health and homelessness address the concerns and opportunities of media involvement. (NCP, 2010, p. 2)

The text that follows is work that we did as a group to summarize all of our trepidations on storytelling our experiences to the media. We worked together to collectively raise our concerns at meetings, and then a few of us from the group pulled together these considerations into a smooth-reading, professional document. This included how when we speak to experiences of homelessness/mental health issues, it puts us at risk of future landlord/employer discrimination, and “that those who are acting as figureheads in the media, by publically identifying themselves, might render themselves vulnerable to further stigma, discrimination, rejection, and potential targeting” (NCP, 2010, p. 3). We also ask for concerted efforts to shift coverage away from ‘hard luck’ and personal trauma narratives towards stories that speak to social determinants of health and “the nature of the experience as it relates to how service systems, the continued history of colonization, institutionalization, lack of equal access to social support and political voice, and
significant discrepancies in how economic situations impact the safety, success and wellbeing of PWLE” (NCP, 2010, p. 4). Another key issue that we mark is our awareness of how peer and participant narratives work as public relations: that peers “working on the project, while representing the interests of the At Home/Chez Soi project should not act merely as promotional tools for the media” (NCP, 2010, p. 5).

We followed by making procedural recommendations, as organizations always want practical ‘solutions’ to the problems being raised. These recommendations included that the Media tips, pros, and cons sheet that we developed in the report be distributed “to participants who have been contacted for media interviews. This will insure that participants have a background for the potential impact of the media on their lives, developed by PWLE who have experienced media exposure” (NCP, 2010, p. 5). Other recommendations included the use of peer workers to act as allies to the participants when considering, conducting, and coming down from media interviews and to act in support roles; and that media education and training be offered to both PWLE and professionals that goes beyond selling the story, to include “a critical analysis of what it means to talk to the media, and multiple ways of framing an issue or story to consider socio-political factors” (NPC, 2010, p. 6).

This generalized summary of concerns and recommendations is followed by a paper which centers concerns about media representation specifically from an Indigenous standpoint. In it, the author raises concern on “the issue of participant exploitation in the service of project promotion,” and the “sometimes inflammatory, sometimes supportive, often marginalizing role that media has played in Indigenous issues in Canada, especially as it affects Aboriginal women; these concerns will be increased for Aboriginal project participants who carry an additionally stigmatizing Western psychiatric label” (NCP, 2010, p. 8). She notes that such popular media
representations of Indigenous homelessness “can best be described as stereotypical, and at worst they can be described as a form of violence, abuse, and exploitation; images which transform the identity of the person from that of a ‘family,’ ‘friend’ or ‘neighbour’ and redefines their identity into something society has to pity or be afraid of, has to regulate, monitor, and protect our streets from” (NCP, 2010, p. 8). Importantly, she centres ongoing colonization as absent from the stories that get told in media sound bites, including the “500 year history in this country of dominant culture members making determinations regarding the nature and place of Indigenous peoples in society.” Her work also notes the ways that ongoing colonization produce Indigenous subjects: “Colonization has had a huge impact on our identities as Indigenous peoples. There is not one of us left whose identity is not formed through either a choice to assimilate and adapt, or to fight and reject the assimilation process and form our identity in reaction to the efforts of colonization” (NCP, 2010, p. 9).

The document ends with the “So you’re going to talk to the media?” tips, pros and cons tip sheet that offers key considerations specifically directed at participants within the project. Like most documents produced for organizations, we knew that we had to appear ‘balanced’ and ‘neutral’ in our approach to the topic, and not focus only on the negative: or we would be understood as negative. So we worked to produce balance, highlighting the pros of media engagements: things like the opportunity to “share your perspective and experience with many people”; “media stories sometimes draw attention to important issues, and can make a small contribution to creating change in society”; and “you can give hope to others in recovery, and reduce stigma, by voicing your perspectives” (NCP, 2010, p. 15) These are the common tropes that are used to promote storytelling, what mental health practitioners and researchers have come to call “contact-based education,” recently deemed one of the most effective way to reduce the stigma
associated with mental illness (Patten et al., 2012). Contact-based education means associating with people with mental illness. Once, during an MHCC board meeting over lunch, a professional asked me if I knew what contact-based education was. I replied no, and she quickly told me that it was the work that I was already and always doing. Thus, to do this work, I simply need to be a peer body in space.

The tips sheet also highlights the cons that can come with speaking openly to the media about experiences of homelessness and mental health issues: these include “what you say to the media may not exactly be what is published in newspapers and shown on television;” that with the internet, such stories can become eternal, and that your “future employers, friends or family members will be able to read your story, and know about your history and experience as it is represented in the media;” that often reporters press for very personal disclosures, and the aftermath of such exposure can bring including negative responses from social networks, and that “you may feel that you have been taken advantage of by the media because the newspaper or television station got more out of the interview that you did” (NCP, 2010, p. 16).

Tips to mediate the impact of media representation that we put forward included emphasizing that speaking to the media is not a condition of remaining a project participant and that your housing and safety are not conditional on agreeing to speak to the media on behalf of the project; strongly encouraging participants to use a pseudonym as a way “to still get your perspective out there, without making any personal sacrifice;” having a support worker accompany you through the media process; ask to review the interview questions prior to the interview; and to seek help in reviewing how the media outlet has previously reported such stories (NCP, 2010, p. 18).
Ken reflected on the process of developing the document as “a good microcosm for the way in which I think about peer informed, peer knowledge. It’s not about the raw experience totally; it’s about how we turn it into knowledge and turn it into practice after that. And I think that process kind of happened in the media discussion report.” We recognize that our knowledge is a commodity: that we take raw experience and use it as knowledge that in turn becomes commodified. The Media Discussion Report is a negotiation on how stories as a commodity should be traded: some rules and regulations on how to proceed with them. When we finished this document we sent it to the national operations team for review, and as a sitting member I worked to mediate the outcomes of our document recommendations. The document was well taken up, and some of the content ended up shifting conversations about media representations.

What generated from the document was policy that could be implemented to better protect participants and peers when speaking to the media. The work that we did here was understood as helpful: helpful to the project in ensuring that safety, informed consent, and that risk mitigations were met. As Norman notes, the report and the “talking to the media pamphlet, like, they’re tangible things that we have now that we didn’t have going in.” As some of our recommendations were integrated into project procedures and made useful, it also worked to show that peers can produce useful work particular from our lived experience not only of mental health issues/homelessness, but also our experiences of working as such archetypes. And by taking seriously our knowledge, the project showed that it was making use of us: that we were serious contenders and not tokenistic parts of the assemblage. Not surprisingly, what didn’t get taken up was how our embodied experiences were being used to generate good public relations; nor considerations specific to media representations of Indigenous bodies as ‘the homeless mentally ill.’
There was still some resistance to the ways in which the NCP was conceptualizing media coverage. Again, ‘choice’ rhetoric was used as a ‘common sense’ approach to the topic of media representation and disclosure. Professionals asked if whether speaking to the media wasn’t just a question of choice: that both participants and peer workers would always be told that they could say no to a media request. I know that there were times when I felt pressured to speak publicly to audiences and the press during my work: speaking was a fundamental condition of my work. I cannot imagine that participants, coming out of recent homelessness, felt confident to refute a request coming from those that have ‘saved them’ from the streets. Gratitude was one of their expected conditions. During one public engagement, when I raised the complicated nature of storytelling, an audience member weighed in by suggesting that it was the least that participants could do: she spoke in ‘we’ language, and given that she was not a part of the project, I can only think that she meant ‘we’ to mean as a nation, and as taxpayers. We have helped them, given them housing and support. Isn’t it the least they could do in return: share their stories of how we have helped them? I learned to answer that housing is a human right, not an indebted favour.

More than anything, there was an overriding sentiment that as peers, we were being paternalistic towards project participants: disempowering them by assuming that they could not make choices for themselves. This was not recovery-oriented practice. Our interventions were read as individual: that we were only concerned that participants would have personal crises and distress stemming for media exposure, rather than directed at the cultural crisis that required us to reveal our stories for the systems to keep working. This is a limit to peer work: it often becomes about personal dis/empowerment rather than critiquing larger systemic processes. It becomes about us, and whether we are ‘equipped to handle’ media exposure, rather than the problematics of how stories are taken and used.
The main thread that was pulled from and built on from this document was the recommendation to produce a tipsheet for participants prior to media engagements: it resulted in a media pamphlet. During an operations team meeting after a review of the document, it was agreed in Summer 2010 that a pamphlet could easily be produced through the Communications Department that could condense the ‘pro’s, con’s, and tips’ that we had identified, and thus be made widely available to project participants before they spoke to the media. The production of this pamphlet was thus put into the hands of the Communications Department. By fall 2010, as press coverage and thus the demand for participants to speak to the media grew, we became concerned with the time it was taking for the pamphlet to be produced. By the end of 2010, with no pamphlet in sight, we worked to create a tipsheet that was circulated to all of the lead researchers and service provider agencies asking them to use this sheet in the meantime.

Part of my work became pressing on the Communications Department to realize the media pamphlet. In early 2011 we saw an initial text draft: it had been heavily mediated on, depoliticized, and a direct quote from an NCP member that highlighted a negative experience of speaking to the media had been edited so that it read as ‘less negative.’ I took the draft to the NCP for review, and we edited back. This process happened a few times.

By summer 2011 (a year later) we saw a pamphlet prototype. The NCP agreed that it was good enough. Yet the pamphlet was credited as having been created by the Communications Department. I pushed back, noting that it was our idea. They pushed back, noting that they had done substantial work on our idea – in particular, on moderating our language and producing different text. We, pissed, pushed back, noting that we had no control on that fact that they had insisted on editing our language. Eventually, we agreed on “This pamphlet was conceived by the National Consumer Panel and jointly developed with the Communication Department.” The final
product, “Talking to the Media: Issues for participants to consider about media interviews” was released in October of 2011, a year and a half after the NCP had made the recommendation.

None-the-less, this was good product. As Ken noted, “in the end we had a practical piece that came out of it in terms of the media pamphlet, right?” It was a material thing that we had instigated, sites wanted these pamphlets, and the project worked to ensure that they were distributed. They became a thing to give to PWLE alongside the ask of them to share their stories. Stories, and peer knowledge, are commodities: this report was a negotiation on how such commodities should be traded. Yet, the text in the document that offered recognition of the commodification of our stories, and the critical reflections on systemic and structural oppressions were left unrecognized. It was the practical and practice-based recommendations that were taken up: how we can continue to move stories out in ways that are peer-approved.

Still, pamphlet production was limited: organizations outside of the At Home/Chez Soi project wanted them, but we were told that production was too costly, and that they had to be kept internal to the project. When one site coordinator ran out of pamphlets, she had to work very hard to get the Communications Department to produce more of them. There was resistance to circulate these pamphlets widely: I suspect it had something to do with raising awareness about the minefield that is media representation. In effect, the caution that we raised about speaking to the media within the At Home/Chez Soi project was counter-indicative to the larger work that the MHCC was pushing forward in their anti-stigma initiatives: to get PWLE to speak their personal stories in order to raise awareness about mental illness, and by extension, awareness about the work of the MHCC.
One of the things that organizational texts do is act as labour indicators. Producing text shows evidence of activity: that organizational targets are being met. The NCP used both the Media Discussion report and the pamphlet as proof of peer labour. But interestingly, who could lay claim to the media pamphlet as work was contested. The Communications Department, in the process of developing an annual report of their work products to be presented to the Board of Directors, let us know that the media pamphlet would be listed as one of their work products for 2011. The Department made the point that they had, in effect, materialized the pamphlet. I was irritated, but submitted, and the pamphlet was added to their long list of outputs for 2011. As an organizational process, this shows how easily products, including peer products, are absorbed into organizational bureaucracies. What started as a peer political project to alter the ways in which the Communications Department was uncritically relying on PWLE as public relations for the project ultimately became a product that was added to their list of accomplishments.

Regardless, the early project work that the NCP did on media engagements positioned us as a go-to group to consult with as the project continued to work to develop a public face for the project. Press matters: the more coverage the project got, the more pressure it put on governments to make policy change to sustain funding for Housing First programs when the project funding ended in 2013. With more funding for Housing First post-project, the better position both the project and the MHCC were to declare it all an organizational success. Peers and project participants were always invited to speak at public engagements throughout the course of the project. Speakers Bureaus for participants were formed. Mid-way through, the project established a relationship with the National Film Board, and commissioned what ended up being a joint NFB/At Home/Chez Soi website which collected 50 short films about the project: short films that featured the assemblage of bodies that made up the project, including landlords,
service providers, researchers, peers, and project participants, which is all viewable here: 

http://athome.nfb.ca/#/athome. The NCP consulted on early stages of that development, and we were able to make small inroads: including the construction of a two-staged filming consent form that allowed for participants to withdraw their consent to publish the film after they have viewed a rough cut product. This was unusual process for the NFB: offering this out to people after they had already financially invested in production was not usually done. But they agreed, and indeed some people, including participants, decided to withdraw consent after viewing the rough cut of their short films.

In essence, these small textual and procedural interventions on how PWLE were used to publically promote the project made a difference. It changed the ways in which ‘people with lived experience’ could be used as a commodity to promote the project. While this peer work changed policy, labour that can be understood as ‘working up’ to change structural processes, the target of this work remains abjected bodies. In effect, our consultation allowed the project to continue to mobilize us as public relations agents, yet to do so in a way that was more ethically considered, and peer approved. While this work set new precedents for project procedure, it failed to impact the way in which the MHCC more widely worked and continues to work.

7.4.2 Naming Trouble without Getting into Trouble: White Civility and the Stigma, Discrimination and PWLE Discussion Report

In July of 2010, during one of our NCP in-person meetings, many of the peer workers were discussing the difficulties of doing peer work within the project, and the endurance it took to occupy such a subject position in a work role. This was emerging as what became ongoing consensus: peer work is hard to endure. With everyday microagressions accruing, the NCP became a place for peers to cite structurally embedded and micro moments of discrimination
they experienced doing peer work. Collectively, we decided that we should turn these experiences into a product (and productivity) by writing about it. Instead of documenting our own experiences, we would generate a broader conversation about the possibilities, constraints, and debates of working as peers. We consciously knew that we had to frame the document in a way that wouldn’t implicate the project directly as a problem, but rather frame this as an opportunity to share peer experiential knowledge on issues that peer workers face. As Ken notes, there is always that tension of “being positive and negative,” and as peer workers working in mental health fields “we’re staying positive. Like, everything needs to be positive. You know, let’s make this meeting positive. So instead of saying here is the discrimination in the project, because that’s very loaded, so to write something like that could get us in trouble, let’s look at a positive spin, in order to prevent stigma and discrimination … so that’s the goal, and then you prevent those situations, instead of focusing on the situations themselves.”

Talking about peer work as difficult is a difficult thing to do. It can easily be read as ‘the work is too difficult,’ and having that attributed to our peer status (i.e. mental illness). I felt this at times, when I was struggling against the machinery of the project: that this struggle was interpreted as personal. I heard others speak of peers that had left the project as doing so because of personal struggles: rarely interpreted as political resistance, even when they indicated it as such. Indicating peer work as difficult due to the complicated nature of sustaining such a subject position within systems of power is risky. In particular, it is dangerous to do in an organization of which one of its major priorities is integrating PWLE into workplaces, and with workplace mental health and wellness being a major focus. To say that peers working for the MHCC are having a hard time is to say that the organization is not doing its job. The MHCC did yearly organizational evaluations, staff survey check-ins to see how they were doing in supporting staff. One year, incorporating PWLE into their organization received a low ranking. To address this, a
senior MHCC professional organized a teleconference for MHCC staff who were PWLE to talk and gain insight into how the organization could do better. There were three of us on the call. I spoke frankly about the difficulties of working in a peer role, and dealing with the power dynamics that saturate the work when you are there to speak from mental illness for an organization that is trying to prevent it.

Soon after the call, one of my supervisors was in touch. I learned that the MHCC professional took from the call that my supervisor needed to do a better job supporting me in my work. It was understood as a managerial issue, not a systemized one. I was upset, because this supervisor, fabulous, was one of the only things that actually sustained my ability to do the work. My supervisor was upset: my marking the trouble of peer identity and peer work ended up getting them into trouble. And then, I suddenly felt in trouble. I learned that marking trouble gets people into trouble. “Being in trouble” became a concern that continued to follow me whenever I made a work intervention. I ended up asking, often, if I was in trouble, after doing or saying something that troubled what was happening in the work. One of my major learnings was how to try to do things that would not get myself and others in trouble: my supervisor called it learning to work in a business environment.

In Coleman’s *White Civility: The Literary Project of English Canada*, he shows how allegorical figures in early Canadian literature allows for tracing “the ways in which these regularly repeated literary personifications for the Canadian nation mediated and gradually reified the privileged, normative status of British whiteness in English Canada” (Coleman, 2006, pp. 6-7). Coleman argues that in order to sustain nation-building projects of Canada as a naturalized White and English space, it requires work. This includes drawing on English notions of civility - good polity, conformity to the principles of social order, polite or liberal education - as well as holding
liberal ideals that all people hold the potential of acquiring white civility and of becoming civilized (Coleman, 1996, p. 10). Importantly, white civility becomes an organizational strategy that consistently works to solidify standardizing ideals of whiteness, masculinity, and Britishness. Instilling white civility is an ongoing project of attainment: more than something a person or culture simply has; it becomes something that a person or culture does (Coleman, 1996, p. 12). White civility as a cultural practice attempts to bring order and organize divergent social realms, including business culture. As Coleman notes, “the idea of civility as a (White) cultural practice not only made it a mode of internal management and self-definition, because it distinguished the civil from the uncivil, but it also made it a mode of external management, because it gave civil subjects a mandate for managing the circumstances of those perceived as uncivil” (Coleman, 2006, pp. 12-13).

One of the central conditions of peer work is that we perform white civility. Or, at least, that we make efforts to perform white civility. That is, as peers, we are allowed moments of unruliness, so long as we use them as learning moments to move us forwards towards performing civility. As I’ve argued in chapter 4, peer identity must straddle both respectability and degeneracy: we need to read at once as both authentic enough to represent the homeless mentally ill, and professional enough to integrate within professional realms. Part of that incorporation depends on showing, through the work that we do as peers, that we are learning ways of managing our unruly bodies and making progress by incorporating within white civility. Learning white civility as peers participating within established work environments is a gift: when we fail to perform it, we are reoriented towards it. A paradox of peer work is that we show that we are willing to abandon the incivility which makes us peer in the first place. Being brought into the assemblage is a project. For peers, it is a project of learning how to negotiate our unruliness, manage it, and learn how to progressively work towards embodying and embracing white civility.
What ended up being the NCP produced “Stigma, Discrimination, and PWLE Knowledge Discussion Report” very much mirrors this learning. It is a document that carefully and politely speaks of the constraints and troubles of peer work while at the same time highlighting the possibilities and positives of working in this labour field. The report is textually mediated: we as a collectivity learned that we had to be careful how to cover the topic without getting ourselves in trouble, and to do so meant not writing anything that might negatively reflect on the organization. A condition of peer work is learning to name troubles without getting into trouble: this document works to do just that. Even choosing to title these texts ‘discussion reports’ works to mediate the authority of the text: it says, ‘we’re just discussing here,’ mitigating both our and organizational authority and liability.

The “Stigma, Discrimination and PWLE Knowledge Discussion Report” is divided into five sections: the first section grounds the history of peer involvement in the consumer/survivor/ex-patient and mad movements, and follows with pieces written by four NCP members reflecting on factors that contribute to discrimination towards PWLE. Section Two offers an overview of peer work, and offers four pieces by peers outlining their work within the context of the project, marking the importance of peer workers, the labour that they do, and some challenges in the field. Section Three offers an overview of peer involvement in each of the five project sites: NCP members from each city wrote specifically about their site and how peer participation had emerged in their respective community. Section Four speaks to peer involvement nationally: a section I wrote on the importance of having peer-only groups. And Section Five offers conclusion and recommendations.

Thus, while the document raises some issues about the difficulties of experiencing discrimination, and doing peer work, it is tempered by the way that we generalize these issues in
broad sweeps and write of them as issues and debates that are facing peer work more broadly, and not necessarily the experiences that we are having directly in our work positions. Importantly, from an organizational perspective, the report documents the extensive peer involvement that has been funded and supported by the project: especially the detailed accounts of the local and national involvement of peers in the project. The text in itself not only works to highlight the extensive peer involvement that the project has carried out, but the very fact of the text shows that this participation is ‘meaningful:’ we have written a text. As Ahmed notes when discussing the pressures of performance culture in organizations, “the point of the document can be to have a document you can point to” (Ahmed, 2012, p. 90). This document became something that again we could point to as part of peer-only productivity, but it also became a text that the project, and eventually the MHCC, could point to as proof of their investment in peer work, as “the body of the document becomes part of the body of the institution” (Ahmed, 2012, p. 93).

For the NCP, the performance of the document wasn’t as much the focus as was the practice of pulling the document together. Almost all of the twelve members of the NCP contributed a piece of writing: some were well-seasoned writers, for others it was their first time authoring a piece. When all of the various pieces were amassed, the writing styles, voices, and levels of comprehension varied drastically: there was little cohesion to the pieces that ended making up the report, but we decided to prioritize leaving the disjointed nature of multiple voices over editing the document into one cohesive voice. This choice was made in order to honour members writing contributions over prioritizing a professional, smooth-reading document. Some text was written in first person, other text in third person. Some text was respectable, mirroring professional report writing; some was degenerate, relying on informal and spoken word text. By
being committed to keeping it fragmented, we were able to keep a diversity of voices, and show that the ‘peer collectivity’ is similarly fragmented.

Ahmed notes that “a working document is one that multiple actors work over,” (Ahmed, 2012, p. 93) and this was certainly the case with this document – from conception to finalized draft, the 50 page document took over a year to complete. It was something that we were working on. The team-writing of organizational texts can work to build camaraderie: “many practitioners suggest that documents are not in themselves the point: what matters are the groups that are created in the process of writing them” (Ahmed, 2012, p. 90). Many of those that I interviewed confirmed this point: that it was the process more than the outcome that mattered. As Ken noted, “people took ownership of the editing within the group, and there was like a subcommittee almost of editors, which was great too. And people really took that on, edited the paper.” This group community-based best practice of collective writing was understood by Ken as ‘capacity-building,’ one of the core tenets of recovery-oriented practice. He notes how the group writing process “probably made for a little more time being spent on it, but at the same time one of our goals in peer support and everything else was building capacity, so I think it helps, it was a good little piece in that.” The production of the text is an exercise in and of itself: for peers, an exercise in community and capacity-building through group work.

One of the outcomes of the document was that as a group, we all slowly learned together how to voice issues without raising concerns. This is the pressure of white civility, and part of the peer condition: to be polite and professional when discussing issues that cause trouble for us when relating to organizational culture. As the founder of this group, my work was to learn how to manage myself and others in ways that would be read as productive and polite. This work is evident in the report: we worked to smooth out the language and tone of the document so that it
wouldn’t be taken as an affront, yet still be able to generate a civil ‘discussion’ about the incivility of discrimination. When we presented a draft to the operations team, it was met as a success: we had succeeded in writing a text that spoke of bad things in good ways. The sentiment of being proud of us circulated: it was the common sentiment when we accomplished productivity.

It was agreed that this document should be an external one: not internal to the project, but rather sent to the Communications Department for formatting and branding, and be released as an MHCC document: posted on the MHCC website, added to their long list of reports. This was an achievement: for many reasons, including tensions between the At Home/Chez Soi project and the MHCC proper, getting a peer written document released as an MHCC report was measured as success. It was sent off to the Communications Department, and one staff was in touch to speak to me about the text. They were excited, saying a text like this had never been produced before, and that this was a great moment for peers. This spoke to me of the general lack of knowledge in the organization about the history of the consumer/survivor/ex-patient and mad movements, and how our long history of knowledge production aren’t taken up as foundational texts in mental health fields.

As the text moved its way through the organization towards finalization, during one in-person meeting the operations team was presented with a couple of prototype pages of formatting that were to give us a sense of the layout and look of the document. It was a moment, because markedly, the two pages of layouts pulled from the report and projected on the screen in the boardroom were both ‘story’ text: two members had written personal accounts of experiences of discrimination, and it was those two pages, out of more than fifty, that were pulled from the text, formatted and branded for our preview. For impact, dramatic sentences disclosing these
experiences were pulled and separated from the text as quotes, and in enlarged and different-coloured font, were made pronounced as central features of the page. I was irritated, but not surprised that the Communications Department would know how to do best and focus on what was familiar: individualized accounts of the hurt of discrimination. But I was surprised when one senior operations team member voiced their own irritation: flustered and angry, she voiced how ‘this,’ meaning personal stories, was not what the document was about. That it was about systems of discrimination and how inclusion works against exclusion, and that the MHCC better not focus only on personal stories when promoting this work. For me, this was a stand-out moment of pleasure in the board room. It marked that it was not only peers who saw how our knowledge was being categorized and taken up: as contained and condensed to embodied experience, with everything else being left undigested.

Another moment came when the document was almost finalized: a quiet email communication to me from a senior project member asking if I was going to clean up the text of the report so that it read in a more professional tone and would thus be more accessible. They knew that I was capable of this work: as an academic, big words came more easily to me than the ‘plain-language’ text that was used when trying to relate and communicate to participants. This was a moment that well illustrates the trap of what being pinned to peer identity and work produces: always bridge work, always teetering between professional respectability and authentic degeneracy. In staying authentic to the words and language that peers wrote, the report risked reading as incomprehensible to traditional professional organizational documents. I understood the email as a result of goodwill: the text could be read as embarrassing, solidifying notions that peers are incapable of writing professional texts. I responded by saying that it is often left up to us as peers to decipher professional language, and that in this instance we were leaving it up to
the reader to stretch their abilities of gleaning knowledge outside of dominant ways of conveying it.

This moment prompted us to add a note in the executive summary on knowledge production, taking up the organizational language of ‘knowledge transfer and exchange’:

The NCP recognizes that knowledge transfer is also very much about the way in which you convey knowledge, along with content. For this reason, this document celebrates multiple ways of expressing voice and knowledge through writing, with the understanding that just as there have been dominant socio-political systems at play in the lives of PWLE, the same can be said for dominant exclusionary communication systems which dictate in what form knowledge should be presented. The NCP is not only looking to make language more accessible through plain language, but also hopes to de-center the traditional way of creating reports and papers. Thus, this discussion report embraces a wide range of voices and writing styles, and leaves it to the reader to draw on their own capacity to value and understand knowledge as it emerges in a variety of forms (NCP, 2012, p. 4).

Once finalized, the discussion report was posted online, (available here: http://www.mentalhealthcommission.ca/English/node/698) and what it did from there is hard to say. Certainly the purpose and hope of the document was that in future, things would be done better. However, Sally voiced skepticism on the effect of the document: “I don’t know, the Stigma and Discrimination paper, like how well did that get distributed? I don’t know how many people saw that, so probably not as many as could have seen it.” This reflects Ahmed’s point that “if the policy is written by someone who is viewed as lower down in the organization’s hierarchy, then the document might be less taken up” (Ahmed, 2012, p. 89). Yet Ken notes, “in the end it got posted on the website and was available publically. Which I think is great, you know, it’s there. It is specific to the project, but I think it can still lend itself more widely, so it’s a contribution to future projects that are like At Home/Chez Soi, but at the same time can lend itself to talking about discrimination and knowledge in general for consumer/survivors.” In practice, it didn’t alter the project procedures as with the media discussion report, yet it was a
source of pride for peers and professionals alike, that we produced public text. And it at once worked to authorize peer participation as a best practice that produces product, and manufactured the hope that the process of peer participation would proceed better when planned in the future.

7.4.3 Watching our Language: NCP Discussion Note on Language and Mental Health Issues

The last document that the NCP wrote collectively was a one-page ‘discussion note’ on language (we initially wanted to call it a position paper, but were dissuaded from using language that could be interpreted as ‘polemic’). The MHCC, at some early point in their formation, decided to agree on the consistent use of ‘mental illness and mental health problems’ to describe madness. Consistent messaging was important for the Commission: it creates a sense of uniformity, reliability, and truth to the unruly nature of madness. As White notes, the Commission had been “advised to create (amongst themselves) and communicate (to the public) a clear, unified vision and to establish clear goals as the priority of the Commission … if consensus cannot be established organically, it must be created” (White, 2009, p. 238). Somehow, ‘mental illness and mental health problems’ together had become the official language used to describe us. It is consistently used in their texts, and somewhat awkwardly yet dutifully repeated in public speech acts.

The At Home/Chez Soi project, funded by Health Canada and managed through the MHCC, was its somewhat disorderly and somewhat uncivil cousin. Our annual budget was larger than the whole of the Commission’s, and was funded after the initial launch of the Commission, and thus a temporary ‘add-on’ to the MHCC’s priorities. More than anything, the project added real live bodies to the organization: the Commission was built primarily as an advisory think-tank, build to construct policy recommendations to governments. Our project was the only initiative that
funded direct mental health services to mad people. Moreover, these bodies were homeless: messy unruly bodies that brought with them the stain of criminal justice contact, criminalization, racialization, colonization, violence and abject poverty. The MHCC had not anticipated having to cope with the mess of not only the ‘homeless mentally ill,’ but also the professionals and peers who came to work for the project. Many of us working for the project were a different breed than the people that the MHCC would hire as staff: we were people who had worked in homeless interventions, some of whom were social justice-oriented in their approach to the ‘crisis.’ For the MHCC, the project was hard to contain, and this also meant that the peers who came to work on the project were not necessarily the sanitized version that the Commission proper was interested in bringing into the assemblage: for instance, those who were committed to the language of illness and problem. Organizational consensus is hard to build: the entire project posed an unexpected conundrum for the MHCC in that it shifted circulations of power, and brought into the fold a diversity of professionals, peers and indeed ‘the homeless mentally ill:’ bodies that they had not anticipated managing when first formed.

In practice, this meant that the project was hard to govern: there were moments of crisis and ongoing work that were outside the immediate purview and rule of the MHCC proper. This makes consensus hard. To illustrate a small fraction of this unruliness, while the MHCC had decided through created consensus to consistently use the language of ‘mental illness and mental health problems’ to describe us, some project professionals and peers were irritated by the consistent building of us as bodies that were only suffering: bodies of illness and problem. In this way, the MHCC was seen as having the “effect of reinforcing, rather than destabilizing, dominant representations of madness as a social problem in Canada and mad peoples as non-citizens” (White, 2009, p. 235). In practice, the project was using language that created inconsistency for the Commission: at times, the language of psychiatric survivor and madness
came out at public events, but more than that, those working for the project were at times raising social justice issues of colonization, racial, queer and gendered violence and discrimination, and poverty. While the Commission continued its refrain of us as ‘problems and illness,’ at times the project veered from this consensus. At public events, an MHCC representative often opened a session, and in suits, hair styled and speeches prepared, their bodies often worked in stark contrast to the project employees and participants who followed them. Between the MHCC and the project, there was a visible gulf in language use, presentation, and point.

Some project peers, both within and outside of the NCP, expressed frustration with the MHCC’s insistence on using language to describe us that was reductive. Many of us had informally become accustomed to using the language of ‘mental health issues’ to describe distress. I came to use it constantly and consistently, a language use that was familiar enough to most that it wasn’t a violent disruption, but at least worked outside of purely biomedical frameworks. A condition of my work was to find language that moderated: to give way to language that was mediated between radical and biomedical frameworks. Some professionals favoured this language as well, and were using it in official document drafts within the project. I was told of how draft project documents would be sent to the MHCC for review, and inevitably sent back to the project with the language of mental health issues crossed out through track changes and reinscribed with ‘mental illness and mental health problems.’ One professional told me how they would in turn reject these revisions, and send them back, but it was always a losing battle. ‘Created consensus’ won, and all MHCC official communications about its initiatives, including the At Home/Chez Soi project, spoke of us as illnesses and problems.

In NCP meetings, these issues were raised. Other members spoke about this as a concern in their local peer groups, which ultimately led us to mark this tension in a ‘discussion note.’ While some
members of the NCP understood themselves to have mental illness, and others as people with lived experience, consumers, survivors and mad, we had a lively discussion and reached a consensus of our own: that we were all comfortable with the language of ‘mental health issues.’ Quickly written and approved by the group, we sent this one-page document to the operations team. Absent from this text is any direct mention of the primary motivation behind its writing: that it was written in response to the MHCC use of ‘mental illness and mental health problems.’ Again, we were trying to name trouble with getting into any of our own.

**NCP Discussion note on language and mental health issues**

The National Consumer Panel is an advisory group that works in consultation with the MHCC’s At Home/Chez Soi project. The Panel is made of people with lived experience of mental health issues and/or homelessness. As a group, we are committed, as the MHCC is, to fight discrimination and stigma that is often directed at people like us. One of the ways that we encounter stigma and discrimination is through the power of language. Often, we hear ourselves being spoken about by others in ways that are (sometimes unintentionally) hurtful -- as one-dimensional problems that need to be fixed. We know that within the MHCC and wider social contexts, we are referred to using a number of different value-laden words, with our states of being described in such ways as mental health challenges, mental health conditions, suffering from mental illness, metal health problems, and mental health issues. While we as a group understand that language is fluid and its meaning is always changing, we notice that much of this language expresses a negative understanding of our state of being, and find that stigmatizing.

As a group, we have discussed at length the ways in which we feel shamed when we are referred to only as a diagnostic category or an illness. We’ve reflected on our views collectively, and while each of us has a different personal preference on how to name and describe ourselves, as a Panel we are comfortable putting forward that the language most neutral and positive to describe us is “people with mental health issues.” We came to this consensus because we note that “mental health issues” doesn’t imply that everything that we go through is inherently negative, and it remains outside of diagnostic and problem-only frameworks. We felt the need to put out this discussion point because we are intensely aware that people both within the mental health field, and in the general public, are most comfortable using language that is more targeted, specific, and concrete than the language of “issues.” But that is precisely why we prefer such language, as it insists on nuance, complexity, and the grey areas that constitute our inner lives. We understand that it is sometimes difficult to pay attention and re-adjust the conversational
language that one is accustomed to using. We hope that given that this is coming from the people for whom you seek to describe – people with mental health issues – that you will respect how it is that we wish to be spoken of.

In this text, we use our experiential authority to try to make a conceptual shift. The operations team responded to it warmly, with many of the team noting that this was their preferred language use already, and others making a conscious shift to use ‘mental health issues’ instead of the constant refrain of mental illness. I noticed that afterwards, some professionals used ‘issues’ when speaking to peers, and continued to use ‘illness and problem’ in more official venues. Still, the movement of the text beyond the operations team was constrained: it was made clear that this was to remain an internal document – not to be made public. A contradiction in the MHCC created consensus of us as problems and illnesses from within the Commission would be bad public relations. Around the NCP table, we joked in mock surprise that this document wouldn’t make its way to the MHCC website. We were able to circulate it within the project: in particular, the local peer groups appreciated the text. One of my supervisors did circulate it via email to a handful of MHCC employees: the leads for each MHCC initiative. I was cc’ed, and received one response from an initiative lead: markedly, it was not a ‘reply all’ email, only an individual reply to me, thanking the NCP for this work. From there, the document met an organizational dead end.

It did end up making some traction in the public realm. In June 2012, the NCP presented as a panel at the 5th International Stigma Conference in Ottawa, co-sponsored by the MHCC. One member presented on the politics of language, and read this document out to the audience. They also provided hand out copies of the document, which were quickly consumed. I failed to intervene on this public communication and distribution of the document. It was eagerly received, and like the internal media pamphlet, other organizations wanted to use this document.
In conversation after the panel presentation, an employee from another large national mental health agency asked for the document. She said it could be put to great use, because it solved a problem for her: of what to call ‘us’ in her policy documents. By using our experiential authority to inform professionals on how to name us, we help solve ongoing dilemmas: our experiential authority sanctions us to tell respectability to do better, which authorizes them in turn to proceed authentically and with confidence in the continued work that they do. Hence, peer participation is a technology which, while sometimes interrupting business-as-usual, is now becoming a central component in actually allowing organizations to carry forward in the ongoing work that they do.

7.5 Conclusion: Working Through the Peer Paradox

In this work I have shown how peer identity and peer work have emerged within the specific context of the At Home/Chez Soi project. I have argued that becoming a peer subject has been made possible through a variety of discursive formations including the crisis in representation, the recovery movement, diversity, inclusionary and participatory practices, and the c/s/x and mad movements. Chapter 4 denaturalizes peer identity by showing that acquiring, producing and performing a peer identity requires work: that is, peer identity is not innate, but rather something that has recently been forged as possible, and people are motivated to position as peers because of the opportunities for inclusion within systems that have historically excluded us.

Yet with inclusion comes exclusion. What are the basic underlying conditions and limits of peer participation within mental health assemblages? In essence, who and what must we exclude in order to ensure inclusivity within the project? In chapter 5, I show that one of the main conditions of performing both peer identify and peer work is through storytelling: in particular the expectation that peers tell a particular kind of recovery-oriented personal story. In this way,
we learn to govern, replicate, and reproduce the stories that are expected from us. And even when we work to speak stories that are critical, the possibilities of our stories being heard and recognized as anything other than tragedy-to-triumph narratives are limited. Through repetitive bindings, our personal stories contribute to building liberal grand narratives of us as bodies and populations, the building of organizations that intervene on us, and of continued nation-building.

In this chapter, I show that the work that we do as peers is primarily to act as embodied knowers: that we are to draw on our lived experiences of homelessness/distress in order to support, govern and manage similar others. And when working to inform professional practice, the value of our work is based in using our experiences of marginality to inform practice. In both cases, peer work is most effective when we draw on raw experience and act as peer informants to participants, other peers, and professionals. The limits of peer involvement are made evident when we push to use our knowledge analytically to question, intervene on, or disrupt the foundational frameworks of the project. That is, when we make moves to use our knowledge in ways that risk problematizing the prevailing regimes of ruling, peer workers become trouble. Thus, fundamental to peer work is that we learn to adapt to the terms of our engagement: that we follow the rules of white civility and organizational performance culture. While we are able to make small inroads in changing project procedures, these are fragile moments with small effects. Herein lies the paradox of peer work: our work is largely contained to conjoining with other systems of governance to help in the management of the ‘chronically homeless mentally ill.’ Our knowledge, when (rarely) directed at ‘studying up’ to query the regimes of truth that govern mental illness, has little effect and must be managed. While we are brought in as peers to represent ‘the homeless mentally ill’ -- figures that are characterized as resistant, abject, and unruly -- we must learn to manage our ‘nature’ and become docile bodies as a condition of sustaining our role within the assemblage.
This being the case, as peer identity and peer work becomes normalized and solidifies in practice, how can we put pressure on peer work so that it moves beyond current limits and conditions? In this moment, peer participation lends authority and authenticity to prevailing ruling regimes by incorporation our bodies into the fold. We are included in as docile bodies doing self/governing work, and thus become cogs that allow the machinery of mental health systems to keep moving. How can we shift the possibilities of peer work? What is evident is that we will always be informants: meaning that when bodies of difference are brought into ruling regimes to represent, we will always be pinned to our difference. Yet currently, our roles as ‘peer’ informants are stuck to diversity and recovery frameworks: that is, through diversity frames, we are brought in as difference to add spice to normalcy; through recovery models, we are given the opportunity to mold ourselves and others into recoverable selves. In this way, peer inclusion is normalizing: particular bodies up to the task of embodying peer properly are brought into the fold so long as they are willing and able to train under and comply with normative standards of being.

This is the fundamental problem with the politics of inclusion: we gain entry into regimes of power as difference but only by replicating systems of domination. Rather, as Razack notes, we need to move forward with a politics of accountability. That is, that a condition of our incorporation cannot be premised solely on embodied difference, but rather must make use of it to articulate how our difference is produced and maintained through systems of domination and subordination (Razack, 1998, pp.159-160). I have shown here some of the paradoxes of peer work. In the following Afterword, I explore the nexus of contemporary issues that the participatory turn in mental health presents us with, and try to imagine differently.
Afterword:

I will sit like a bird on a fence
Sing you songs with a happy ending
Swoop down and tell you that it don’t make sense
To attack the very thing you’re defending . . .
But if you’re gonna dine with them cannibals
Sooner or later, darling, you’re gonna get eaten

Nick Cave & the Bad Seeds, 2004, Cannibal’s Hymn

8.1 Afterwards

As I move away from this project, my entanglements with peer identity endure. I remain tethered to the peer paradox of inclusionary practices. Peer remains something that at times I embody, actively do, and advocate for. On a personal level, I continue to both benefit and be reduced by promoting myself as a peer. And I remain deeply critical of it, always working to complicate the very premises in which participation relies.

As alternatives to the dominant biomedical mental health system, both inclusionary practices and the recovery model are technologies that we helped devise and advocate for with the hope that these tactics would offer more. In the last two decades, these tools have fundamentally changed the ways in which mental health governances proceed. Inclusionary practices have rescaled the landscape: through inclusion, some of us with usually denigrated experiences have been able to refashion ourselves into recoverable citizens. Yet, as I have shown, participatory tactics have been absorbed and added to the arsenal of technologies that work to retrench us as the locus of problem and concern, a collective body to be worked on and normalized. I sit saturated by the benefits of recovery and inclusionary practices. Yet they also, now, restrict our movement.
Beyond recovery is a hard place to get to. Beyond inclusion is a place we need to get to. We have become trapped by our alternatives, and need to desire for more. My writing offers an opportunity to think through the contradictions, tensions, and paradoxes of peer inclusions, with the aim of unsettling others the way I have been unsettled by becoming a peer worker.

While this work contributes to a broad range of critical fields, it specifically makes significant contributions to three critical disciplines: Critical Disability Studies, Mad Studies, and Survivor Research. By questioning the productivity of inclusionary goals, this thesis contributes to the field of Critical Disability Studies. In particular, in recent years Disability Studies has queried the limits of the disability rights movement by showing the limits of the recognition and assimilation of disabled people within the legal, social, cultural and economic systems that still continue to largely depend on the subordination of others. In response, the paradigm of disability justice has emerged to show the limits of equality frameworks, and rather orients towards models of disability justice that “embraces difference, confronts privilege and challenges what is considered ‘normal’ on every front. We don’t want to simply join the ranks of the privileged; we want to dismantle those ranks and the systems that maintain them” (Mingus, 2011, ¶ 5) By showing the limits of incorporation into systems of power, this study aligns with disability justice frameworks by showing that the inclusion and recognition of some is always based on the exclusion and sustained subordination of others.

As a contribution to Mad Studies, while this work offers a critique of prevailing regimes of ruling, it more importantly places at the center of this thesis questions of our own will to power and agency as subjected people within the matrix of inclusionary practices. Mad studies as an emerging field must not only confront the psy power complex, but also map the effects of the moves we ourselves make as mad people: through our own fractured identities, subjectivities,
essentialisms, experiences and knowledges. This study places primacy on querying our own strategies and politics of resistance by calling into question the state of social movement activism and scholarship within the current ‘peer’ and ‘people with lived experience’ moment. Further, this work contributes to the discipline of survivor research by using such methodology to align with psychiatric survivor politics, with the end goal of helping inform the psychiatric survivor movement about the nuanced ways in which the landscape of neoliberal mental health assemblages are being reconfigured in new ways through inclusionary practices.

Currently, peer participatory practices contribute to what Snyder and Mitchell term ‘ablenationalism;’ the ways in which inclusionary practices within biopolitical neoliberal economies work to sustain disabled people as exceptional bodies, and valorize “able-bodied norms of inclusion as the natural qualification of citizenship” (Snyder & Mitchell, 2010, p. 113). In this way, inclusion becomes a way of orienting disabled people towards the governing norms of productivity and independence within political economies (Mitchell & Snyder, 2015).

Inclusion absorbs: it fetishizes, consumes, and reifies difference, yet paradoxically, to be good peer workers we must act as recoverable bodies by making efforts to manage and subsume our madness. And thus, we undertake complicated attempts to commodify our difference, while the normative order remains undisrupted. As Titchkosky notes, “‘normal’ is enforced, imitated, enacted; taught and bought; sold and recycled” (Titchkosky, 2015, p. 131). Inclusion is a process which sustains normative sets of terms which allow a body to become recognized as subject and citizen, rather than troubling how notions of normalcy underpin ongoing projects of abjection.

To participate, or not to participate, is this the question? To argue for the abandonment of peer inclusion is a difficult provocation: there are plenty of bodies that are eager to turn the possibilities of ‘people with lived experience’ into a vocation. Indeed, I often justify my own
incorporation by rationalizing that my critical edge offers something more than what other peers might bring to the table. This might simply be just that: a justification. Yet, in current ‘peer’ practices, myself and others are sometimes using our positions as peer informants to push further. We often meet foreclosures. To challenge these dead ends, we need the terms of our engagement to change. Specifically, inclusionary practices need to stop being premised on recovery and diversity frameworks, but rather reorient understanding our difference through paradigms of oppression and subordination.

Many of us are using the opportunity that inclusionary practices afford in order to try to subvert, destabilize, and manipulate the participatory turn beyond its current logics. Here, I propose that to imagine otherwise requires a shift: from abandoning our participation as peer informants, towards including ourselves into the fold as ‘mad informants.’ This means politicizing rather than personalizing the informant role. We will always be informants when brought into the role of representing: yet as peer informants, we currently must check our political “guns and stones” at the door (Said, 1989, p. 210). As mad informants, we would no longer be brought in to represent others, but rather be representing critiques of the methods in which we are made Other. As an alternative, the mad informant would look otherwise: we would use our experiential knowledge to act on dismantling oppressive systemic interlocking practices of subjection rather than to speak of the pain that distress and discrimination causes us. In this context, Critical Studies, including Mad Studies, offer promising tools. Conceivably, this is a hard commodity to market. Yet, as I have shown, systems of governance offer ever-changing, always re-organizing and permeable cartographies of power.
8.2 Aftermaths and Afterlives

Meanwhile, back at the ranch …

Lucy Costa, Systemic Advocate, the Empowerment Council [Colloquial]

Meanwhile, the waiting list for affordable housing continues to grow, disability benefits are under renewed scrutiny through audit cultures, and welfare cheques stay static. There is now a new waiting list. The line up to become a peer worker is growing. Time and again I sit in meetings where ‘people with lived experience’ express this new hope of becoming peer paraprofessionals in the field. Peer work has become a programming module within recovery-oriented care. Participation has become a ‘treatment method:’ as part of mental health care recovery practices, service users are now being trained on how to tell their story, on how to effectively participate, and on how to become a peer support worker. This means that part of our treatment has become learning how to govern ourselves and others, and to recalibrate as potential peer workers amongst organized civility.

Despite the fact that peer work pins us to our embodied experiences, there is a growing consensus, both with people with lived experience and professionals alike, that lived experience is not enough. This means that peer workers are largely comprised of people with university degrees, and/or professional job experience. Yet in the imaginary landscape of peer work, the promise that peer work will offer us a solution to the large body of those excluded from the workplace because of madness is a potent one, and continues apace. This is a fantasy that peer workers as ‘recoverable selves’ help promote through our corporeality when working with service users. Although we cling to the dream that peer work will present an alternative to unemployment, peer work opportunities remain fragile, precarious, and few and far between. This creates new competition amongst us: as limited opportunities, the professionalization of
peer work means those with professional credentials are often those that secure peer employment, settling for reduced security and wages; while those unwilling/unable to straddle civility remain outcast from the promise of peer work.

This thesis has mapped how particular experiences of marginality have now been transformed into a commodity, governed by rules of trade. Peer roles help to restructure political economies of care within neoliberal frames. While there are clear benefits related to bringing in marginalized workers through peer work positions, paradoxically, peer work is a form of precarious labour that contributes to the deskilling and fragmentation of the unionized health and community service sector workforce. By deskilling common tasks usually carried out by professional and unionized workers (such as social workers) onto a paraprofessional peer workforce, the ‘inclusion’ of peers into low-paid contractual work minimizes the need for high-skilled labour. Thus, the use of peers in social and health sector service delivery is not simply a matter of inclusion, but also entails a shift towards low-paid often non-unionized labour and is thus part of a complex gendered political economy of care work – what has been termed affective labour.

The At Home/Chez Soi project ended two years ago. The structures that worked to build the project were easily dismantled at project end, often into new assemblages. As a pilot project, the At Home/Chez Soi project did not require long-term investments. Some project staff moved on to continue to work in other mental health research and service system formations. As a whole, the pilot was considered a success; especially given that the federal government explicitly and repeatedly cited the project as providing an evidence base leading to federal policy change. In this way, it appears that evidence-based research leads to policy change. This is a sleight of hand: in practice, the changes were minor, and largely entailed an enforced shift (not an increase) of
funds for local municipalities who apply for (time-limited contractual) Federal Homelessness Partnering Strategy funding. To qualify, organizations now have to position their programs as following Housing First models (http://actionplan.gc.ca/en/initiative/homelessness-partnering-strategy). While the Housing First model in theory has now been legitimized through evidence-based research, the financial investments required to fully implement this model across Canada remain small.

The peers with whom I worked in the project too have moved on. Some have moved to more secure work (both peer and non-peer designated); others remain in similar roles with other organizations; while still others are unemployed. Flexible precarity is the term best used to describe both our work, and our lives. The aftermath of the end of project funding has put many project participants back where they were. Some are back in shelters, on the streets, and endangered. The project worked very hard to sustain the housing and supports that had been created through the project at the provincial level. Ontario is the site of success: all participants housed through the project will remain so. Other sites were mixed: alternatives were found for many participants, yet much of what was found were the same housing solutions that created housing insecurity for them in the first place: transitional housing and rooming houses that, once rules are broken, would have them evicted back out into the streets. The hope expressed at the beginning of the project – that all participants, including those in TAU, would be housed in Housing First programs if our research results proved promising enough – were, if not forgotten, cast into the realm cultural amnesia.

This year, the MHCC received a 10-year renewal of its funding from the federal Conservative government: the safety of the Commission has been secured for another decade. In this sense, the Commission as an intervention has been the biggest success story, in that it will continue to exist
as an organization. Its renewed mandate does not include housing and homelessness as a priority. The meaningful participation of people with lived experience within the organization remains emphasized, often cited first in its list of priorities.
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Appendices

Appendix A

Consent Form

People with Lived Experience Involvement in the At Home/Chez Soi project

Who I am and what the research is about:

My name is Jijian Voronka and I am a PhD student at the Ontario Institute for Studies in Education (OISE) in the Department of Humanities, Social Sciences, and Social Justice Education. I am conducting a study for my PhD thesis about people with lived experience (PWLE) involvement in the At Home/Chez Soi project. Much of my research involves my own ethnography of the At Home/Chez Soi project, and my reflections working for the project as a consumer research consultant, drawing on my own experiences of mental health issues and homelessness and how such experiences informed my work in a peer (peer here defined as person with experiences of homelessness/mental health issues) role.

I’m interested in what the experience of working within a peer role, either in an advisory or employment capacity, has been like for other peers in the project. I’m interested in topics like what it has been like for you in a personal, professional, and community level to do peer work, and the successes, difficulties, and possibilities in doing such work. I believe that there are many valuable lessons to be learned from how peer work has been undertaken in the At Home/Chez Soi project, and also know that the experience of peer involvement has varied. To ensure that I get a sample of different experiences, I hope to interview between 10-15 PWLE who have been involved in peer roles within the At Home/Chez Soi project (2-3 peers in each site).

I would like to invite you to participate in this study be sharing your own experiences of peer work within the At Home/Chez Soi project.

What is involved in this study?

In order to participate in this study, you must be a PWLE who has worked either in a peer advisory role or in a peer employment role for the At Home/Chez Soi project. This includes (but is not limited to) peer support workers, peer researchers, peer organizers and facilitators, and peers who sit on committees in an advisory capacity (for example, on Local Advisory Committees, on the National Working group, on local peer groups, on local project teams etc. as a peer representative). You can either be someone who currently works for the project in a peer role, or be interviewed as someone who did so in the past.

As a participant you will be asked questions about your experiences of working specifically within a peer role for the project. For example, I will ask why you think it is important that PWLE of homelessness and mental health issues work in within your field of employment, what difference it makes to non-peer professionals who work alongside you, for participants, and for other PWLE. Leading up to the interview, I will offer to send you the interview guide of questions so that you have time to reflect on the questions that I will be asking. You will be asked to commit to one interview of 1.5 to 2.5 hours. Interviews will be held over the phone, or in-person when possible, at a place most convenient to you.

Your participation in this study is fully voluntary. You can refuse to participate, and you can refuse to answer any question at any point of the interview or withdraw from the study at any time without
consequence. If you have completed an interview and later choose to withdraw, your transcribed tape will be destroyed and will not be used in this study.

Confidentiality

In order to best represent what you convey throughout your interview, I would like to digitally audiotape the interview. However, you also have the option of choosing not to be audio taped, in which case I will take notes during the interview. If you do allow the interview to be audio recorded, each digital file will be destroyed immediately after it has been transcribed.

All the data that identifies you personally, such as your name and contact information, will be removed from the transcripts, as well as any third parties mentioned in your interview. The transcribed data will be kept on a password protected USB memory device which will be kept in a locked drawer in my home office. Only myself and my supervisor will have access to the transcripts. Once I complete my thesis, I will destroy all transcripts. Your name will not be shared with anyone.

Further, to minimize the risk of identification, I will put certain safeguards in place. Your interview will remain anonymous, you can choose a pseudonym of your choice or I will assign you one, and this pseudonym will be used throughout the study to represent your data. I will also not identify from which of the 5 sites you work within, nor will I identify any organization or committee for which you are/were active (just generally, whether it was in research, service provision, advisory, etc). When the study is presented to others or written up, no information that identifies you or your story will be included. Your original name will not appear on any of the documents, other than the consent form, which will be kept at all times in a locked drawer in a locked room to which I will only have access.

I will include some portions of our interview (both paraphrased passages and/or direct quotes) in my research findings and final dissertation, and possible future publications. If you wish, you have the opportunity to review a summary of research findings that are drawn from your interview, and let me know if there are any portions of the research summary you feel could render you recognizable to anyone who will read it. I will exclude any information or text you want to be excluded.

What are the risks and benefits?

In the short term, by participating in this study you many personally benefit from having the opportunity to discuss your work with someone who has a similar background and experience in peer work within the At Home/Chez Soi project. In the longer-term, by participating in this study you will be contributing to knowledge about the imperatives as well as the challenges of doing work in a peer role, as well as contributing to learnings on how to do peer engagement best in future.

There are no foreseeable physical or legal risks in participating in this study. The social risks in partaking in this study include the risk that you are taking in speaking about your experiences as a peer within you workplace. These risks are minimized due to confidentiality, as well as the fact that the project will be over before study is written up. You do not have to disclose to anyone that you have taken part in this study. You may also feel some emotional discomfort during the interview process while speaking about your experiences as a peer within the project. I will employ all means to ensure the interview is conducted to your comfort level, and we can stop the interview at any point if you wish.

Compensation and costs

You will be offered an honorarium of $40 for your participation in this study. If there are any other costs associated with your participation in this study (ie public transportation costs for in-person interviews, costs associated with cell phone charges), I will reimburse you for such expenses.
Publications and Summary of Results

I can provide you a summary (electronic and/or paper) of the research findings from your interview if you request one. You can then review my findings from your interview and choose to withdraw any data that you feel might jeopardize your confidentiality, or that you simply would not like to have in the final research results.

Contacts

Dr Sherene Razack, a senior faculty in Sociology and Equity Studies in Education, OISE, is overseeing this study and can be contacted at any point if you have any questions or comments regarding this study. You can also contact the Office of Research Ethics at ethics.review@utoronto.ca or 416-946-3273 at any time with questions you might have about your rights as a participant in this study. If you have any questions or concerns about the study or would like an update on its status, please do not hesitate to contact:

Jijian Voronka Or Sherene Razack, OISE
321 Chisholm Avenue 252 Bloor Street West
Toronto, ON M4C 4W5 Toronto, ON M5S 1V6
416-995-4354 416-978-0177
Jiji.voronka@utoronto.ca sherene.razack@utoronto.ca

Sincerely,
Jijian Voronka
CONSENT

I understand the information presented about the study. I have had the opportunity to discuss this study and my questions have been answered to my satisfaction. I consent to take part in the study and to participate in one interview of approximately 2 hours in length with the understanding that I may withdraw from the study at any time without penalty. I can also refuse to answer any question at any time without penalty.

Participant’s Name (Please Print)  Participant’s Signature  Date

I voluntarily consent to being audio taped for the interview.

☐ Yes  ☐ No

Participants’ Name (Please Print)  Participant’s Signature  Date

I would like to receive a summary of the research findings.

☐ Yes  ☐ No

Participants’ Name (Please Print)  Participant’s Signature  Date

I confirm that I have explained the nature and purpose of the study to the person named above. I have answered all questions to the participant’s satisfaction.

Name of Person  Signature  Date

Obtaining Consent
Appendix B

INTERVIEW GUIDE

PWLE involvement within the At Home/Chez Soi project

Biography and background

1. Can you tell me about your background as it relates to your current work?
2. Can you tell me about the work that you do within the project?
3. How did you come to this work?
4. Is your work explicitly a “peer” position?
5. Have you held other peer positions prior to you work within At Home/Chez Soi?

Nature of the work

6. Can you describe what your everyday work within the project consists of? (probes dependent on what kind of position it is – research, PSW, advisory, etc.)
7. How does bringing a peer perspective to your work affect how you do you job? Can you give me some examples of how you draw on your lived experience to inform your work?
8. How do you think having a peer within a team (or at the table) changes the group dynamics? Can you think of some examples?
9. Can you think of some examples of contributions that you have been able to make because of your peer knowledge?
10. Can you think of moments in your work that were really empowering – contributions that you made in your role that a non-peer wouldn’t have been able to actualize?
11. Can you think of times when it was difficult occupying a peer role? Did you work with other peers, or were you the only one in a peer-defined role?
12. What role does a good ally play for you? Did you have one, and if so – what makes for a good ally?
13. In terms of your own career accomplishments, are there ways in which you surprised yourself about your capabilities in your role?
Peer involvement project-wide

14. What are your reflections on how peer involvement developed within your site. Were there lots of opportunities, or could there have been more? What worked, and where could there have been improvement?

15. Were you a part of a local peer-only group? If so, what was that experience like for you? Was it the first time that you had worked within a peer-only group? Did you find it empowering? What work did you do within that group that was particularly rewarding? Were there any challenges that you faced within the group?

16. Did you sit as a peer representative on any of the national groups (e.g. NWG)? What was that experience like? Did you find that you were able to make meaningful contributions as a peer within that group? Did you find learnings working across different stakeholder groups?

17. Did you sit as a member of the NCP? What was that like for you? What were the positives, negatives, and learnings? Is there work that you are especially proud of? What about travel/logistics/support? What were the intra-group relations like? Did you feel like we accomplished acting in an advisory capacity to the project? Where did we have great impact, and where were we less successful?

18. In your role, did you have the chance to associate with other peers (across sites?). What was that like for you?

Overall reflections

19. What are your thoughts about the At Home/Chez Soi project now that it is coming to an end. Are they different than when you first started with the project? What has changed?

20. What do you think about the Housing First model? Have your views changed since your work within At Home/Chez Soi?

21. Do you think that working within a peer role will improve or hinder you future work opportunities i.e. now that you are out, do you think that this will help/hinder your future employments?

22. For you, what is the point of peer involvement in the project? What were the opportunities for the project? What were the opportunities for peers? Any closing thoughts, or things that you’d like to tell me about?