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Article

Epistemic oppression and sites of resistance in mental health systems

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Abstract
The epistemological foundation of Western psychiatric mental health service systems within North America was conceived within colonial and reductionist agendas that perpetuate systemic racism. This epistemological hegemony has been the primary hindrance for transformative social work and the achievement of social justice for racialized services recipients in mental health systems. One of colonialism's most indispensable tools is epistemic oppression. While many organizations have focused on equity movements (i.e., Equity, Diversity, and Inclusion (EDI) or Anti-Oppressive Practice) to address inequities and oppression, these initiatives have not been effective in challenging the power structures perpetuated by epistemic privilege. The pervasive question that has plagued my social work practice in mental health has been: can epistemic and social justice be realized in mainstream medicalized psychiatric-based systems that are designed to perpetuate existing power structures? This article will help address the complexity of this question through a critical analysis of the presence and impact of epistemic oppression in mental health, its harms, methods of resistance, the appropriation of EDI, and implications for social work practice.

Keywords
psychiatry, mental health, social work practice, systemic racism, epistemic oppression, decolonization, EDI, social justice

Résumé
La base épistémologique des systèmes occidentaux de services de santé mentale psychiatriques en Amérique du Nord a été conçue dans le cadre de programmes coloniaux et réductionnistes qui perpétuent le racisme systémique. Cette hégémonie épistémologique constitue le principal obstacle à un travail social transformateur et à la réalisation de la justice sociale pour les bénéficiaires des services en santé mentale issus de groupes racisés. L'un des outils les plus indispensables du colonialisme est l'oppression épistémique. Bien que de nombreuses organisations aient mis l'accent sur les mouvements pour l'équité (c'est-à-dire l'Équité, la

Diversité et l'Inclusion (EDI) ou les pratiques anti-oppressives) afin de lutter contre les inégalités et l'oppression, ces initiatives n'ont pas réussi à remettre en question les structures de pouvoir perpétuées par le privilège épistémique. La question omniprésente qui me tourmente dans le cadre de ma pratique du travail social en santé mentale est la suivante : *la justice épistémique et sociale peut-elle être atteinte dans les systèmes psychiatriques médicalisés dominants, conçus pour maintenir les structures de pouvoir existantes?* Cet article vise à aborder la complexité de cette question par une analyse critique de la présence et de l'impact de l'oppression épistémique en santé mentale, de ses effets néfastes, des méthodes de résistance, de l'appropriation des approches EDI et des implications pour la pratique du travail social.

Mots-clés
psychiatrie, santé mentale, pratique du travail social, racisme systémique, oppression épistémique, décolonisation, EDI, justice sociale

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Introduction

Epistemologies "have the power not only to transform worlds, but to create them. They can not only disappear acts of violence but render them unnamable and unrecognizable…" (Berenstain et al., 2022, p. 283).

After completing my Master's in Social Work, I eagerly started a new chapter of my already established career, rejuvenated and hopeful. I dove into working more formally in mental health and engaging in Equity, Diversity, and Inclusion (EDI) work in mainstream healthcare systems. While I continued to witness the remarkable resilience of workers and service recipients, the deft application of worker skill within managerialist constraints, and good intentions from organizations, I also observed the recolonization of service recipients, workers, and equity work. I came back into doctoral studies much later with more questions than answers about how to navigate power in these systems, and whether transformational change can actually happen within these mainstream medicalized systems. While organizations work tirelessly to supposedly address power imbalances, power structures do not seem to change. The difficulty seems to be in the firm entrenchment of a positivist biomedical epistemology in mental health systems. And if ideology and epistemic privilege are immutable, transformational change seems unlikely. Through engagement of theoretical literature on the epistemic underpinnings and dynamics of mental health systems through a decolonial framework, as well as my recent mental health practice experience, this article offers a critical analysis of the presence and impact of epistemic oppression in mental health, its harms, methods of resistance, the appropriation of EDI, and implications for social work, all in an attempt to grapple with the question of whether or not epistemic and social justice can be realized within mainstream mental health systems.

Epistemology involves ways of knowing, theories and bodies of knowledge, and how "power relations shape who is believed and why" (Collins, 2000, p. 270). The epistemological foundation of Western psychiatric mental health service systems within North America was conceived within colonial and positivist agendas that perpetuate systemic racism. One of colonialism's most crucial mechanisms is that of epistemic oppression, which is defined as the "persistent epistemic exclusion that hinders one's contribution to knowledge production" (Dotson, 2014, p. 115). This insidious tool often goes uncredited, but perpetuates systems of power and influence, and manifests structurally and systemically.

The emergence of psychiatry was shaped by the 17th century Enlightenment ideals where science began its hegemonic reign (Sharma, 2021). This involved promoting the positivist epistemology of the global North (e.g., North America, Europe, Japan, South Korea, Australia, New Zealand, etc.), which includes principles of objective empirical data collection that uncovers universal truths that are assumed to be natural and immutable (Wieseler, 2020). This reductionist approach espouses categorizations and psychiatric labelling underpinned by biomedical models of mental health that do not recognize elements outside of the dominant biomedical understandings. It also deprives the "non-expert" of the right to access knowledge or challenge prevailing knowledge claims (Mills, 2014, p. 42). These principles were reified within psychiatric institutions in the 17th and 18th centuries, with the prevailing narrative that people who were mentally ill were a danger to themselves and society and needed to be segregated (Hickling, 2020; Spillane, 2018). Atrocities such as lobotomies, electroshock therapy, etc., were considered acceptable and supposedly empirically-based treatments at the time (Spillane, 2018). This approach seemed to pathologize deviants in society, which is reflected in the fact that "homosexuality" was a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Fernando, 2002; Salize et al., 2008), which is the definitive mental health diagnostic guide in North America. In the late 20th century, the movement toward de-institutionalization, which involved returning patients back into the community, yielded evidence of a lack of adequate supports and long-term engagement with mental health systems (Salize et al., 2008).

Another perpetuating factor is the induction of psychiatric mental health services into a capitalist system that creates a dependence on the economy of ever-expanding diagnoses defined by the DSM and funded accordingly in mental health service systems (Johnstone, 2021). The commodification of these biomedical categorizations is connected to resource allocation for service recipients that is being administered by workers that are being de-skilled due to neoliberal financial constraints on mental health systems (Johnstone, 2021), as well as the demand, sale, and consumption of pharmaceutical treatments. Mills (2014) discusses how pharmaceutical treatment, as psychiatry's main intervention, is a colonizing mechanism in using "the swallowing of a pill, to travel deep inside populations of the global South" (p. 7). One of the many insidious methods of pharmaceutical proliferation was illustrated in India where there was a high rate of suicide amongst farmers (Mills, 2014). They had been sold pesticides that were destroying their crops, putting them in positions of poverty (Mills, 2014). Rather than theorizing suicide as an escape from poverty, the "medicalization of suffering" allowed them to be

diagnosed with a mental illness and medicated, falling prey to the same capitalist system that threw them into poverty in the first place (Mills, 2014, p. 43). In addition, marketing medication, under the guise of psychoeducation in high-income countries, have encouraged people to label their symptoms, self-diagnose, and seek out pharmaceutical treatments from their doctors (Mills, 2014).

Colonial epistemic underpinnings of psychiatric mental health systems

The aforementioned dynamics provide optimal conditions for the integration of oppressions such as systemic racism, which is embedded in the psychiatric system through definitions of mental health and illness constructed by dominant groups to subjugate supposed inferior groups (Turner & Kramer, 1995), as well as assessments and diagnoses that reflect the concerns of those in positions of privilege (Rollock & Gordon, 2000). An early example includes the designation of drapetomania, defined as the desire of slaves to run away from servitude, as a mental illness in initial editions of the DSM (Fernando, 2002). More recently, Black service users experience excessive forcible hospital admissions, overdiagnosis of schizophrenia and underdiagnosis of depression, excessive administering of medication often by force, enforcement by police, overrepresentation in medium and high-security facilities, and are less likely to receive counseling or other alternative treatments (Keating & Robertson, 2004).

This historical foundation aligns with colonial epistemology that deems the colonized and racialized subject and their ways of knowing to be primitive, traditional, simple, and underdeveloped (De Sousa Santos, 2006). Thus, the global North, characterized as a progressive and thinking entity, distinguished themselves from the traditional knowledge of the global South (e.g., Africa, Latin America, the Caribbean, and parts of Asia and Oceania) where the local and specific were deemed less credible than the global and universal (Sharma, 2021). A resulting colonial epistemic strategy is the "disappearing" of knowledge of the marginalized where indigenized knowledge (localized traditional knowledge of a group of people indigenous to a particular geographical area) is subordinated in favour of "Western epistemic practices" (Dotson, 2011, p. 236; Sharma, 2021). This annihilation or "murder of knowledge" (p. 92) was identified by De Sousa Santos (2014) as epistemicide. Bailey (2020) describes the fate of Indigenous traditions and ways of knowing as such: "The unlevel knowing field is a hungry place where all knowledge that fails to nurture and sustain dominant ways [of] knowing risks being dragged onto the dominator's epistemic home turf to be mined, coopted, consumed or destroyed" (p. 667).

The impact of epistemicide is illustrated in the eradication of Indigenous ways of knowing around mental health with the colonial genocide of Taino communities in the Caribbean. They had an informal communal system of care where those deemed to have mental illnesses wandered freely, were fed by the community, and were treated with baths and salves (Hickling, 2020). When enslaved Africans were brought to the West Indies (Caribbean) by Europeans, mental health amongst Black people was not initially recognized. It was the responsibility of plantation owners to manage or care for their "subjects/slaves" who they deemed to be mentally

ill (Hickling, 2020). Incarcerative measures and institutionalization were the treatments at the time, with no regard or recognition for alternative non-European cultural practices around mental health. “The concept of involuntary commitment, custodialization, and compulsory detention for patients with acute mental illness is a product of modern European civilization and to this day underpins much of the contemporary European mental health agenda” (Hickling, 2020, p. 20). The amalgamation of colonial and positivist ways of knowing around mental health results in psychiatric imperialism that weeds out and discredits non-Western understandings of mental health as “irrational and inappropriate interventions” (Mills, 2014, p. 3). This is reflective of Foucault’s (1972) recognition of the power of dominant structures to determine what statements are true (Mills, 2014) and therefore, which epistemologies and voices are subordinated and silenced (Dotson, 2011). Medina (2017a) identifies “epistemologies of ignorance surfaced by critical race theorists that protect the voices, meaning, and perspectives of some by silencing the voices, meanings, and perspectives of others” (p. 247). Pohlhaus’ (2012) concept of willful hermeneutical ignorance and Dotson’s (2012) concept of contributory injustices mark the refusal of those representing dominant systems to acknowledge the epistemic resources of the marginalized, even when they are readily available. These forces contribute to epistemic imperialism, which “occurs when members of an oppressed group are forced to take on dominant thought and conform their epistemic agency to dominant modes of epistemic interaction” (Wieseler, 2020, p. 718), which is inherent in epistemicidal mental health systems that cannot tolerate alternative constructions of mental health that might threaten its hegemony.

This silencing or suppression of “othered” ways of knowing around mental health is often done in insidious ways, such as gaslighting or appropriation that will be explored later in this paper, but sometimes it is marked with complete incompatibility or intolerance. Such is the case with how hearing voices is constructed. Mental health services tend to strictly adhere to illness models that invalidate other perspectives, which is the case with diagnoses of psychotic symptoms (i.e., auditory and visual hallucinations) and disorders like schizophrenia (Brett & Read, 2025). The Hearing Voices Movement and groups were created under the premise that the medical pathological model of voice-hearing does not foster coping (Brett & Read, 2025). The attempt to normalize and find alternative causation for hearing voices has not been tolerated in mainstream mental health services. I witnessed this first-hand when doing community outreach support where I was instructed not to engage with any delusional narratives that could come from hallucinations for fear of enabling these behaviours.

Epistemological and ontological harms

As will be explicated further, and consistent with my experience in the field of mental health, psychiatrization engenders a Foucauldian surveillance (Mills, 2014), mediated through positivist binaries (i.e., straight vs. queer, disabled vs. able-bodied, sane vs. insane, well vs. sick, and deviance vs. normalcy). The mapping of the world in these binaries creates polarized ways of knowing and being and enables a policing of deviance that forces one’s identification (Hall, 2017; Wieseler, 2020). “You don’t have to have a diagnosis to experience sanism ... you just

have to look, or sound, or feel, or smell a little bit different than the everyday" (Poole, 2014, 4:40). Vatne and Holmes (2006) echo Foucault in noting how religious, intellectual, and medical establishments became examples of civilizing institutions, teaching people how to self-monitor through making their expectations of behaviour explicit. This results in the induction of a "self-colonizing trajectory" where one has to accept the discourse and language of the oppressor as a means of survival (Mills, 2014, p. 77) from epistemic and colonial violence, thereby reinforcing the deference to authority that is inherent in colonial relationships (Razack, 2003). Another outcome is that of testimonial smothering, where a speaker has to censor their testimony of their own experiences or ways of knowing (Dotson, 2011). These dynamics then lead to a silencing of individual service recipient understandings of mental health and wellness in favour of an illness model.

Silencing and internalization are exacerbated by mechanisms such as structural gaslighting, which is when a knower's experience of their oppression is pathologized rather than placed in the context of power structures that created them (Bailey, 2020). This invalidation can result in crushing self-doubt, epistemic labour, and lack of safety when their accounts of harm are not believed (Pohlhaus, 2020, as cited in Bailey, 2020). In medicalized systems, there is a prevailing narrative of doctors acting in the best interest of their patients, backed by empirically validated treatments, conferring an unquestionable authority (Johnstone, 2021). This would make it unlikely for someone to suggest an alternative explanation for their condition that is not aligned with a biomedical model.

The internalization of this oppression can compromise our well-being individually and in communities and can become a public health issue (Bailey, 2020). This can be illustrated in patients' dissociative adaptive responses to engagement with mental health systems. Thiong (1981) described psychiatry, true to the tenets of colonial epistemology, as "an alienating process where people come to understand themselves in foreign terms, a colonization of the mind" (as cited in Mills, 2014, p. 2). Mills talks about her experience with a patient named Meesha in a mental health NGO in India. Meesha was diagnosed with schizophrenia and distinguished herself from her mother, a psychiatric patient who also heard voices, because she did not have wild unkempt hair like her mother. When Meesha was asked why she took medication, she said in Tamil, "to be cured of this place" (Mills, 2014, p. 1). Meesha had to reconstruct her knowledge of her being and sense of self to become compliant with the mental health system there and seek a cure.

Also, the onto-epistemological impact of these systemic oppressions illustrates the connection between ways of knowing and ways of being (Berenstain et al., 2022; Sharma, 2021). A hermeneutical death, where one is restricted from interpretive capacity, agency, and involvement in epistemic endeavours or communities, has been described "as a form of 'deadening' and a 'numbing' of mental capacities that can kill oneself as a subject of knowledge" (Stewart, as cited in Medina, 2017a, p. 254). It manifests as embodied harms that encompass mental, physical, and emotional effects (Bailey, 2020), and is enabled by organizational structures and processes. An example of this can be drawn from my time earlier in my career

sitting in on an Assertive Community Treatment Team. This was a multi-disciplinary team that provided intensive outpatient case management and medication management, among other supports. For our weekly case management meeting, the lead psychiatrist sat at the head of the boardroom table. He was quite perturbed when we talked about our first case which was about a Black man who was not taking his medication and had decided he no longer wanted to see this psychiatrist. As the discussion ensued about this non-compliant patient, one of the other non-medical workers tentatively put their hand up. The worker was able to offer the information from their conversations with the patient that he was willing to take his medication, but did not want it administered by injection. While the request was accommodated there was no discussion of the experiences of Black men in systems of social control, nor this individual's own constructions of mental health and treatment.

Mechanisms of resistance

Resistance movements have been prevalent since the 1960s and 70s, including anti-psychiatry and critical psychiatry, which heavily critiqued psychiatry and the world views of the "psy" disciplines; and the field had also been critiqued for being mostly led by mental health professionals and academics (Beresford & Russo, 2022). Mad studies emerged in the 1980s and was a resistance movement that was survivor-led (clients/patients/consumers/survivors of psychiatric systems). It is comprised of contributions from sociology, anthropology, social work, cultural studies, feminism, Queer studies, and disability studies, among others (Beresford & Russo, 2022). In addition to these movements were writer activists like Fanon (2004) and Foucault (1972) who specifically engaged with epistemic underpinnings and power. Bridging this work with writers that have contributed to the scholarship of epistemic oppression such as Dotson (2012), Pohlhaus (2012), Medina (2017), etc., representing critical race theory, Black feminist theory and more, has created the basis for the discourse of epistemic resistance. Given the magnitude of the aforementioned harms faced by service recipients in mental health service systems, it becomes imperative to investigate whether there are viable methods of epistemic resistance that can help retain epistemic agency.

Resistance from within the system

The notion of a double consciousness, of both dominant and marginalized perspectives held simultaneously, is a resistant perception that can either allow a person to switch back and forth between these worlds, or has the risk of creating a cognitive dissonance (Medina, 2017a). With this consciousness, we can adopt "an epistemically resistant rather than an epistemically assimilationist strategy, [which] involves changing how one understands the normal and the natural" (Hall, 2017, p. 162), thereby challenging positivist Enlightenment ideals. Johnstone (2021) also talks about clients co-constructing epistemologies with social workers in mental health so as to have their knowledge incorporated into the canon of mental health knowledge systems. This can be facilitated through narrative therapies that create space for service users to construct their own stories. Pohlhaus (2020b) also talks about survival and resistance echoing for

knowers to help collectively share and trust in their own interpretations through stories of resilience that reverberate loudly enough to shake the practices that support gaslighting. While these approaches allow for some pushback on these systems of epistemic oppression, they are not enough to combat the totalizing effect of epistemicide.

Pluralistic approaches alongside the system

Another set of proposals has centered around pluralistic approaches that allow the synchronous existence and operation of multiple epistemologies. De Sousa Santos' (2014) ecology of knowledges puts "othered" forms of knowledge (including indigenized knowledge systems) on a level playing field with scientific knowledge, allowing them to co-exist and interact, thereby disrupting the impenetrable hegemony of Western knowledge systems (Sharma, 2021). Building on this is De Sousa Santos' (2014) postabyssal thinking that recognizes that "the struggle for global social justice must therefore be a struggle for global cognitive justice as well" (p. 124), which requires an epistemological approach that is situated in the global South. Aligned with this re-centering is epistemic resurgence, which involves reclaiming Indigenous cultural, linguistic, and epistemic knowledge and practices (Berenstain et al., 2022).

Imperialist and medicalized endeavours have thus far not allowed for the peaceful co-existence of epistemologies of the colonial subject with equal voice, so it seems unlikely that these alternatives could exist within the hegemonic power structures and biomedical epistemologies of current psychiatric mental health systems, in particular with their integration in neoliberal capitalist systems of commodification.

The fix? EDI and its appropriation

As a means of addressing inequities and supporting inclusivity, many healthcare and social service organizations have adopted anti-oppression (AOP) education, or the currently more popular EDI initiatives. Allan and Hacket (2022) discuss the utility of diversity and inclusion approaches that "offer entry points to addressing the 'Other' that are… more palatable to the dominant norm" (p. 23), versus critical approaches like Anti-Racism, Anti-Oppression (ARAO). Some EDI initiatives can help to create awareness, but are used in a "tick-box approach" and do not result in organizational and structural change (Wylie et al., 2021, p. 317). Many institutions "focus on the 'changing perceptions of whiteness rather than changing the whiteness of organizations'" (Ahmed, 2009, as cited in Allan & Hackett, 2022, p. 24). As noted by Maiter and Joseph (2017), EDI-influenced mental health programs have appropriated cultural epistemologies and recovery language of consumer survivors and "mad people" (p. 764), and co-opted them to serve their own needs, while keeping organizational and medicalized treatment processes intact. As a result, "long-fought-for achievements and progress made through social movements can be rendered indecipherable/unrecognizable once appropriated and enveloped within oppressive structures" (Maiter & Joseph, 2017, p. 764). Much of this is reflective of some of my experiences working in mainstream healthcare systems both as a front-line social worker, and in formal and informal positions in EDI and AOP work. I have been commissioned to create

equity frameworks and statements that have become representations of a value statement, but were not supported to be operationalized into any meaningful initiatives or change. I have been asked to craft training sessions in equity, diversity and inclusion in a way that does not elicit guilt for participants who hold privilege, and I have used language to describe oppression that was deemed too contentious and promptly corrected by senior staff.

Can epistemic and social justice be realized within the system or without?

Pohlhaus (2020a) posits the question of whether some systems are irreparable and should be abandoned. This query alludes to what Pohlhaus (2020a) coins as Dotson's (2011) third order systemic exclusion, which "… occurs when an entire system is inapt for attending to the epistemic interests of particular knowers" (p. 235). This can be the case of mental health systems that are not culturally relevant to its users. Medina (2017a) notes that we need more than a cognitive shift in perspective, but rather systems change at all levels, and Larson (2008) contends that AOP is incompatible with the medical model. Given the aforementioned co-opting of efforts toward resistance or equity in mental health systems, finding a pathway toward the realization of social and epistemic justice within mental health service systems as they currently are seems improbable, and may therefore have to be sought externally.

System disruption and disengagement

Some modes of resistance can facilitate disruption as a potential means to an end. "Disunderstanding" is the strategic refusal to understand or acquiesce in the face of a microaggression, which can be a form of resistance, "and a way of bringing oppressive beliefs 'out of the background and to the fore'" (Pohlhaus, 2011, as cited in Shahvisi, 2021, p. 169). Disunderstanding can take the form of continuing to question someone who commits a microaggression (sender) in an effort to have them explicate the meaning of their words. This sends the message that the subject of this microaggression (receiver) refuses to have their understanding of the situation revised to fit the narrative of the person committing the microaggression (sender). This often results in the sender engaging in particular "moves to innocence", which is where they attribute their actions to an unconscious bias, thereby alleviating both their guilt and complicity (Tuck & Yang, 2012, p. 9). More profound is the "epistemological shudder" that occurs when a prevailing (dominant) knowledge system is presented with "the marvelous" or that which is so completely out of the ordinary, that this system is incapable of making sense of it (Losinsky & Collinson, 1999, as cited in Mills, 2014, p. 125). An example of this could be the idea of normalizing hearing voices, rather than framing it as a pathology that requires treatment and elimination. Then there is the refusal to participate that Medina (2017b) proposes through epistemic disobedience and insurrection, which are responses to the severity of hermeneutical/epistemic death. He notes that in these instances, there is no obligation to negotiate epistemic territory, along with the duty to resist by any means necessary. Medina (2017b) posits that this lack of participation can push dominance to seek new resources and meaning, or to learn othered epistemologies. Aligned with this is Pohlhaus'

(2020b) disengagement, which decenters supposedly natural and universal hegemonic dominant frameworks, allowing space for ways of knowing from nondominant knowers. Lastly is a potential re-positioning in a shift in gaze. Lugones' (2003) idea of vertical versus horizontal attention involves directing "one's epistemic energy toward and in connection with other non-dominantly situated subjects" (Pohlhaus, 2020a, p. 245). This contrasts with vertical attention, which can "undermine resistance to oppressive systems insofar as it prioritizes the agency of those who are empowered by relations of dominance and oppression", and prevents our engagement with each other as marginalized subjects (Pohlhaus, 2020a, p. 245).

Some examples of these system disruptions from my own practice include consciousness-raising and the use of language. I have employed "disunderstanding" by sitting in case conferences or individual meetings with colleagues about a client where a microaggression has occurred in the form of the use of a particular phrase (i.e., "those people"), and continuing to ask the practitioner what they meant by the phrase with sincere but relentless interest and curiosity. As an additional example of consciousness-raising with a racialized client who had been experiencing anxiety-inducing barriers with their insurance company who was questioning their need for mental health supports, I raised the conversation with them about their racial identity and systemic barriers and violences this engenders. This gave the client the opportunity to surface the feeling of being discriminated against in this situation, and then further explore the impact of the racism they had experienced.

From a social constructionist approach, I continue to attempt to reshape and reconstruct understandings of identity and experience by reframing mental health diagnostic terms into the client's own descriptions of their experience, in mental health service documentation. This includes moving toward epistemic justice by using the client's non-clinical language to describe their experience and identity, or using narrative instead of tick-boxes to re-contextualize these experiences. This can help repair the stripping of context, dismemberment, and extraction of only the pieces of identity that are relevant to service systems, which are then reconstructed within the parameters of that system to determine if the client is a good fit for the service.

In addition, I made a concerted effort to develop a community of practice amongst racialized workers who engage in EDI, equity, health equity, or anti-oppression work in order to discuss the barriers of working in isolation with little resources. This can shift our gaze to developing solidarity and move toward a decolonizing of EDI and mental health practice that enhances our collective strengths, rather than having equity work tailored to consciousness-raising for those in power and privilege in a system designed to keep current power structures intact.

Implications for transformative social work practice

The critical analysis presented in this paper reveals implications for doing social justice work in mental health services systems in ways that could attempt to restore epistemic agency for racialized service recipients, depending on where and in what role a worker or clinician is positioned. There are strategies provided to do this within the parameters of the system, with a caution for how these strategies may be appropriated or dismissed. There are also strategies that

can disrupt the system and epistemic hegemony altogether. This could include non-psychiatric survivor-led movements like the scholarship in Mad Studies and the Hearing Voices Movement. This also requires a further examination of the potential co-opting of equity movements within this system to ensure that workers are not complicit with perpetuating oppressions through these initiatives. The hope is to mitigate epistemic and ontological harms, through surfacing colonial and systemically oppressive practices, in order to move toward social and epistemic justice. This could be facilitated through working within psychiatric medicalized mental health system parameters or working with othered systems of mental health care that are predicated on indigenized epistemologies. It could also be pursued by extending our horizontal gaze to look at solutions in solidarity with each other, rather than trying to operate vertically by designing initiatives to educate and appeal to those in power.

Conclusion

This paper has attempted to grapple with questions I have often heard asked by critical social workers in mainstream mental health systems, in terms of how to mitigate harms that are inherent in systems of social control such as psychiatric systems. Understanding the epistemological underpinnings of psychiatric systems that have become invisibilized and normalized through medicalized positivist discourses contextualizes the harms of systemic racism and colonial practices in mental health service systems. Mechanisms of resistance to facilitate epistemic agency, consciousness-raising, and epistemic justice can engage and disrupt these systemic processes. Alternatively, the system may need to be abandoned to find a way to create space for indigenized ways of knowing and supporting mental health. These mechanisms of resistance extend into the use of equity initiatives in organizations that become performative, ineffective, and can actually uphold systems of power. In my experience, being an agent of AOP and EDI in mainstream systems is epistemically laborious and isolating; but then perhaps the objective is to prevent solidarity and insurgence. What if we shifted our gaze and objective? What if we created new systems?

"For the Master's tools will never dismantle the Master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change." (Lorde, 1984, p. 111).

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