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One Flew Over the Policymaker’s Desk: Mental Health Policy Reform in Canada

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Janet M. Phillips
Department of Political Science
University of Alberta
jmp3@ualberta.ca

Introduction

Mental healthcare is a pressing issue in Canada. This is evidenced by the recent flurry of documents produced at both the provincial and federal level surrounding reform. These include *Out of the Shadows at Last*, or 'The Kirby Report' (2006), a report by Canada's Standing Senate Committee on Social Affairs, Science and Technology that painted a bleak picture of mental health services across the country. Out of this report came the federal government's decision to fund a *national* Mental Health Commission of Canada (MHCC), as "a catalyst for improving the mental health system" (MHCC 2013). In turn, the MHCC released *Changing Directions, Changing Lives* (2012), its much anticipated strategy document for mental healthcare reform in Canada. At the provincial level, 2011 saw the release of *Open Minds, Healthy Minds*, Ontario's own provincial strategy document for mental health system reform. Subsequently, in 2012 the Ontario Human Rights Commission released *Minds That Matter*, a report detailing the particular human rights challenges faced by those living with mental illness. Taken together, Canada has seen the release of a plethora of public transcripts surrounding mental healthcare reform in a relatively short amount of time. This raises several questions: How is mental illness problematized in these transcripts? What solutions are advanced for the governance of those categorized as mentally ill? Whose voices are accorded authority in advancing these solutions?

True, mental healthcare reform is not a new issue in Canada. Ontario alone has seen over twenty documents released over the last twenty-five years, all dealing with reform (CMHA 2012). This 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. In this paper, I will argue that recent public transcripts surrounding mental healthcare reform advance an individualized model of mental healthcare that downloads responsibility for a 'meaningful life' onto the shoulders of those categorized as mentally ill. The paper will begin with a literature review of the current discussion around mental healthcare reform, which I suggest is dominated by two themes, recovery and resilience. It will then interpret this discussion with a theoretical framework informed by Foucault's work on shifting definitions of reason/unreason (1965), and Beck and Beck-Gernsheim's theory of individualization (2002). The paper will demonstrate that current discussions around mental healthcare reform privilege an individualized model, which is commensurate with a broader neoliberal rationale, or governmentality (Foucault 1991). This individualized model is problematic because it effectively prescribes individual solutions for what were once understood to be social problems.

Recovery and Resilience

A review of the literature surrounding contemporary mental health policy suggests that mental healthcare reform is dominated by two themes: recovery and resilience. Howell and Voronka (2012) refer to these themes as "two of the central frameworks for organizing mental healthcare in the Western world" (1). Adams, Daniels and Compagni (2009) locate recovery in a broader shift in mental health policy reform (31). Given the importance accorded to these themes, the following literature review is organized around three themes: recovery, resilience, and more recent problematizations of these concepts that take into account their neoliberal context. After defining these concepts, and briefly reviewing problems found with their implementation, I will situate recovery and resilience within broader strategies of individualization and neoliberal governance.

The concept of 'recovery' is central to contemporary mental healthcare reform and to the model of community integration that has been the goal of reform since the deinstitutionalization commencing the 1970s. Piat and Sabetti (2009) inform us that "recovery represents a radically new paradigm in mental health that has emerged over the past two decades, transforming systems of care throughout the world" (17). It is important to note that in this literature, recovery does not refer to cure, but to the ability to live with what is categorized as mental illness. Adams, Daniels and Compagni (2009) note the emergence of the concept alongside "a radical shift in the philosophy supporting mental healthcare […]" (35). Indeed, Pilgrim (2008) pinpoints it "as the harbinger of successful mental health service reform" (299). In the Canadian context, Morrow and Weisser (2012) identify recovery as a "cornerstone" of the 2012 MHCC strategy document (30). The centrality of this concept to contemporary mental healthcare reform begs the question, 'what is recovery?'

A review of the literature informs us that more so than anything else, recovery is "a contested concept" (Pilgrim 2008, 295). Dickerson (2006) identifies the concept as "elusive," meaning that its "implications for services are also uncertain" (647). Mulvale and Bartram (2009) point out "that there is considerable confusion about the meaning," there being "no single, agreed upon definition of the term" (9). Given these claims, it would appear that the concept is nothing if not vague. The origins of the concept in the mental health context shed some light on its elusiveness.

In terms of policy, recovery has its roots in what is referred to as "the psychiatric survivor movement" (Morrow and Weisser 2012, 28). It emerged as a growing concept after failed programs of deinstitutionalization. Anthony tells us that at this point, it became evident that people living with mental illness sought "more than just symptom relief" (1993, 1). As Davidson and Roe point out (2007), advocacy efforts on behalf of "ex-patients, survivors, or consumers or users of mental health services" were geared towards making the point "that people with serious mental illnesses can, and should be entitled to, have a life beyond that of a 'mental patient'" (461). These uses of the concept came about in opposition to the "conceptual or empirical distinctions employed in psychiatric research […]" (Davidson and Roe 2007, 461). What we see then, is tension between scientific and survivors' conceptualizations of the term.

The ambiguity surrounding the concept is attributable to its various and competing definitions. As Piat and Sabetti identify, much discord exists between definitions of recovery as seen by mental health service consumers, and those seen by their clinicians (2009, 19). Pilgrim outlines three different conceptions of recovery: "recovery from illness," or, treatment; "recovery from impairment," or, rehabilitation; and finally, the definition that is most prevalent in the literature on reform, "recovery from invalidation," or, survival (2008, 297). These and other conceptualizations of recovery can be synthesized under Davidson and Roe's (2007) recovery from/recovery in distinction. As they outline,

> Recovery from serious mental illnesses involves the amelioration of symptoms and the person's returning to a healthy state following onset of the illness. This definition is based on explicit criteria of levels of signs, symptoms, and deficits associated with the illness and identifies a point at which remission may be said to have occurred (Davidson and Roe 2007, 463).

As this definition demonstrates, the 'recovery from' model is based upon measurable criteria of improvement in one's condition, stemming from the power of modern medicine to cure, and its corresponding medical authority.

However, as is made clear in contemporary literature on mental health policy, recovery is no longer conceived of as "a final state of cure from the symptoms of mental illness […]" (Adams, Daniels and Compagni 2009, 36). Rather, it is envisioned "as a healing process created by each consumer on an individual basis, according to his or her goals, hopes, aspirations, and strengths" (36). This is what Davidson and Roe have identified as the 'recovery in' paradigm:

> This sense of recovery does not require remission of symptoms or other deficits, nor does it constitute a return to normal functioning. […] Recovery refers instead to overcoming the effects of being a mental patient – including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization – in order to retain, or resume, some degree of control over their own lives" (Davidson and Roe 2007, 463).

In this definition, recovery is not dependent upon the amelioration of symptoms. Medical intervention is no longer the most efficient strategy to coping with mental illness. Rather, recovery is based upon a return to 'normal,' functioning life, with no enforced version of 'normal.' However, in a neoliberal context, it is up to the individual to do this for themselves.

This latter understanding of recovery places responsibility in the hands of the individual: "Recovery is a process in which the person engages to figure out how to manage and live with his or her disorder. […] it is neither something providers can do to or for people with mental illness […]" (Davidson et al. 2006, 643). Similarly, Lunt tells us that "recovery from mental illness occurs in the lives of mental health consumers" (Lunt 2000, 2). However, it also demands that individuals adjust *their* attitudes to adjust to an ever-changing society: Anthony explains that "recovery is described as a deeply personal, unique process of *changing one's attitudes, values, feelings, goals, skills, and/or roles*" (1993, 3, emphasis added). It is the individual who defines what recovery means for them, reflecting the rise of individual authority over that of psychiatry. It is recovery as defined by the consumer of mental health services: "[…] it is understood as a healing process created by each consumer on an individual basis, according to his or her goals, hopes, aspirations, and strengths" (Adams, Daniels and Compagni 2009, 36). While it may entail "clinical recovery," it need not to (Mulvale and Bartram 2009, 9).

In addition to being individual-focused, the literature also identifies this model of recovery as one grounded in leading a 'meaningful' life. Anthony informs us that "recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony 1993, 3). Mulvale and Bartram outline that "recovery is seen as a journey by which a person comes to live a meaningful life, despite having experienced the 'crisis' of a mental illness" (2009, 9). Davidson and Roe argue that "a person with a mental illness needs to be able to have a meaningful, gratifying, and self-determined life while continuing to have a psychiatric disability" (2007, 466). The challenge is no longer to cure, but to adapt accordingly. This literature shows us that recovery is no longer about curing symptoms, but living a 'meaningful' life in spite of them.

However, Jacobson and Greenley (2001) point out that while recovery is an individual process, it does demand a certain environment to be successful. They understand recovery as two

processes: internal conditions and external conditions (Jacobson and Greenley 2001, 482). Internal conditions are "the attitudes, experiences, and processes of change of individuals who are recovering […]" (Jacobson and Greenley 2001, 482). More specifically, these include "hope, healing, empowerment, and connection" (Jacobson and Greenley 2001, 482). These are individualized conditions. External conditions include "the circumstances, events, policies, and practices that may facilitate recovery" (Jacobson and Greenley 2001, 482). In regards to the latter, Jacobson and Greenley suggest that "implementation of the principles of human rights in an organization results in a positive culture of healing, and recovery-oriented services that emerge from such a culture" (Jacobson and Greenley 2001, 484). This raises the question of what kind of mental health system, if any, best facilitates this internal sense of recovery. These internal conditions reflect the preeminence of individualization, discussed above. It is up to the individual to manifest these internal conditions, and find individualized solutions, to an external environment that is beyond their control.

Anthony points out that mental health services guided by a "recovery vision" pay attention to aspects of "self-esteem, adjustment to disability, empowerment, and self-determination" (1993, 4). Ultimately, in a mental health system focused on this definition of recovery, "each essential service is analyzed with respect to its capacity to ameliorate people's impairment, dysfunction, disability, and disadvantage" (Anthony 1993, 4). So, how do we create a system of mental health services geared towards the recovery needs of the individual? Davidson and Roe posit that this system of services must not only "[enhance] the person's capacities" for recovery, but also "[remove] barriers to the person's exercising of these same capacities" (Davidson and Roe 2007, 466). As identified in the literature, this means a system in which "they will have to face no more discrimination or externally imposed threats to their personal sovereignty […]" (Davidson et al. 2006, 644). This reveals that recent shifts in discourses surrounding community prioritize individualization. Services are meant to "facilitate patients' achieving competence, independence, and personal fulfillment" (Dickerson 2006, 647). This literature demonstrates that contemporary reform is centred on finding a system of services that does not hinder the individual from leading a meaningful life, one that is lived in spite of, rather than without, the challenges presented by mental illness.

However, the implementation of this system is problematized for many reasons. As Battersby and Morrow stress, "in practice, an individualistic view of mental illness persists that works against recognizing the contribution of systemic social and structural inequities to people's experiences of mental illness and to their recovery journey" (2012, 104). That is to say, how do we reconcile an individual-focused system with the community, and the social inequalities that are reproduced there? Miller and Rose tell us that "no doubt a whole range of other local shifts in vocabulary in diverse sites contributed to the emergence of community as a valorized alternative, antidote or even cure to the ills that the social had not been able to address – or even to the ills of the social itself" (2008, 89). In this instance, community is presented as a 'valorized alternative' to a mental health system in crisis.

Pilgrim makes the case that tensions in definitions of recovery itself, obstruct the "social determinants of mental health status (class, gender, race and age) and, on the other, the abiding role of statutory mental health services in the social control of nuisance and risk in society" (2008, 303). Morrow and Weisser contend that "recovery without a full recognition of the current social and political context which has eroded social welfare supports will be impotent to foster real systemic change" (2012, 40). Piat and Sabetti suggest that a recovery-oriented system must include "two key stakeholder groups in the mental health system – service providers and

mental health consumers […] and must acknowledge stigma and discrimination as "major barriers" to recovery (2009, 29). Patients are now consumers. Harper and Speed suggest that "the mainstream recovery model" contains "dominant norms of medicine and indeed government […]" (2012, 17). Moreover, this model "offers survivors little in the way of alternatives to the present medical and politically dominant ways of making sense of emotional distress" (Harper and Speed 2012, 17). They also highlight that a system that places so much emphasis on the individual runs the risk of overlooking "collective approaches" (Harper and Speed 2012, 19).

In addition to 'recovery,' 'resilience' is becoming a central concept in contemporary literature on mental healthcare reform. Not as much literature exists on it in relation to the mental health system as does the discussion surrounding recovery, but as the term is often employed in tandem with 'recovery,' it remains central to discussions surrounding contemporary mental health policy. Resilience is a characteristic possessed at the individual level that suggests an environment of constant and uncontrollable challenges. Harper and Speed define it as "an ability to respond to and cope with adversity" (2012, 10). Atkinson, Martin, and Rankin identify it as "the ability to apparently recover from the extremes of trauma, deprivation, threat or stress […]" (2009, 137). It refers to "the innate capacities of people to 'bounce back' in the face of challenges or sources of distress" (Howell and Voronka 2012, 4). O'Malley pinpoints that the concept is surrounded by discourses that reconfigure what used to be "'attributes', such as courage, will-power, fortitude and character […]" (2010, 489). These attributes are now a skill set to cope with a challenging environment. They are now understood "as 'coping strategies' or 'skills' that can be learned by anyone" (O'Malley 2010, 489). That is to say, resilience has become a learnable capacity. It denotes the capacity to cope with rather than change the system.

The literature informs us that "fostering resilience is central to the paradigms of strengths-based practice and recovery models within the mental health field" (Atkinson, Martin, and Rankin 2009, 137). It is meant to function alongside recovery (Howell and Voronka 2012, 4). Recovery is the amelioration of symptoms – or, in the case of mental health, the ability to live despite them, whereas resilience is the ability to withstand challenges that can cause these symptoms in the first place. This is, of course, not just an emerging concept in mental healthcare, but in many other areas as well. As Aubrecht (2012) points out, the concept has become increasingly popular for university students: "There is the growing sense in the university, and popular culture, that mental illness in students is not only 'normal,' but a fact of life" (67). O'Malley notes that resilience is not just about withstanding risk, but embracing it: "Knowing when and how to exploit uncertainty to invent a new and better future is equally a prominent feature of the adaptable, flexible and enterprising subject of resilience" (2010, 506). This is a highly individualized understanding of resilience. Literature surrounding recovery and resilience in mental healthcare reform is primarily focused on what concrete systems of services to implement so as to promote recovery and resilience. What is just starting to emerge, although in lesser quantities, is a literature problematizing the very concepts themselves and the neoliberal framework within which they exist, and in particular, why they are becoming so popular at this juncture in policy reform.

There is little research on the relationship between concepts of recovery, resilience, and neoliberalism in the context of mental healthcare. As O'Malley observes, resilience is a concept tied to neoliberalism (2010, 505). Howell and Voronka echo this claim, arguing that "recovery and resilience, then, are notions deeply embedded with both the economic and the social imperatives of contemporary neoliberalism" (2012, 5). Individuals are expected to find individual solutions to social problems in a society that is constantly changing (Beck and Beck-

Gernsheim 2002; Bauman 2000, 2005). But, an individualized model overlooks the "collective and structural experiences of distress, inequality and injustice" (Harper and Speed 2012, 23). Resilience allows one to bounce back and adapt to these changes. It is the resilient subject who can find these solutions.

This literature also focuses on the relationship between these central concepts – recovery and resilience, and governance. Howell and Voronka claim that recovery and resilience "are powerful tools in the governance of those deemed mentally ill, and also by extension, all citizens" (2012, 4). More specifically, they argue that they help "create a resilient citizenry, able to cope with uncertainty" (Howell and Voronka 2012, 4). In her focus on the university, Aubrecht contends that "wellness publications and programs in the university should thus be viewed as attempts to work not only on student subjectivity, but also as techniques for governing the meaning and experience of difficulty and distress" (2012, 81). This literature shows us that concepts such as recovery and resilience are being employed for the purposes of governance. They are entwined with neoliberal governmentality, as explored in the previous section, as well as its crisis and contradictions. 'Recovery' and 'resilience' are new terms, or old terms employed in new ways, to govern the problem posed by those categorized as mentally ill, or the growing number of those who are ill-equipped to cope with the instabilities contained within neoliberal governance.

Situating Recovery and Resilience in the Mental Health System: Mental Abnormality, Individualization, and Neoliberal Governmentality

Foucault's theorizations around mental abnormality inform us that definitions of reason/unreason are constantly in flux, shifting at the same time as the governmentalities with which they are entwined. However, that the discourse surrounding mental abnormality is always shifting is occluded by its codification as mental illness towards the end of the 1700s (Foucault 1965, x). The Middle Ages featured the image of the Ship of Fools. This functioned to manage those categorized as mentally abnormal by removing them from society, while at the same time subjecting them to the purification of the water upon which they set sail (Foucault 1965, 11). For present purposes, the specifics of this strategy are not important. What *is* important, is the social divide contained within this practice, one that is contained within contemporary understandings of mental abnormality. Foucault explains:

> The madman's voyage is at once a rigorous division and an absolute Passage. In one sense, it simply develops, across a half-real, half-imaginary geography, the madman's *liminal* position on the horizon of medieval concern – a position symbolized and made real at the same time by the madman's privilege of being *confined* within the city *gates*: his exclusion must enclose him; if he cannot and must not have another *prison* than the *threshold* itself, he is kept at the point of passage. He is put in the interior of the exterior, and inversely. A highly symbolic position, which will doubtless remain his until our own day, if we are willing to admit that what was formerly a visible fortress of order has now become the castle of our conscience (Foucault 1965, 11, italics in original).

This 'division' does not function to simply exclude those categorized as mentally abnormal. Rather, it excludes these figures at the same time their presence is written *into* society. Although their physical inclusion/exclusion is constantly renegotiated, they still occupy a place of exclusion within our conscience. This means that despite a physical return to society with

deinstitutionalization, those categorized as mentally abnormal are "kept at the point of passage" (Foucault 1965, 11) – that is to say, they are at the exterior of society while contained within it.

From the Ship of Fools of the Middle Ages, those categorized as mentally abnormal in the Classical Age came to be managed through their physical confinement in a 'world of walls' (this 'world of walls' characterizes liberal ontology [Walzer 2007]) amidst a society defined by its capacity to labour (Foucault 1965, 49). Mental abnormality was problematized alongside idleness in general, part of the "undifferentiated mass" who were the unproductive 'members' of society (Foucault 1965, 48). Yes, this population was provided for by the State, but as part of "an implicit system of obligation"; the individual categorized as mentally abnormal "had the right to be fed, but he must accept the physical and moral constraint of confinement" (Foucault 1965, 48). Mental abnormality was idleness, a moral failing. Nothing else to do with them, those who did not fit the mould of a productive, labouring society were confined as an unproductive whole.

In the Classical Age, this confinement was entwined with disciplinary power and 'normation.' The latter process refers to the disciplining of the abnormal individual with the aim of shaping them into what is a preconceived idea of the 'norm' – that is, the 'optimal' citizen (Foucault 2007, 57). 'Normation' differs considerably from 'normalization.' Entwined with biopower, the latter derives a conception of the norm from the population itself. For Foucault, biopower operates in the compulsion to bring everyone into alignment with this abstract norm (Foucault 2007, 62). In the Classical Age, the abnormal figure, the one who for whatever reason did not labour, was confined. While we have come to establish categorizations within this confined population (e.g. the mad, the elderly, criminals), each of which has come to be managed as its own subset of a population, we are still confining those who do not fit into our contemporary categorizations of normal. At the same time, the category 'normal' has been extended to previously excluded groups, where they are now physically located within the general population. However, while they are physically located within the interior, they are still exterior to the ideological interior, or, what *should* be. As will be explored later in this section, the conditional and limited inclusion of previously excluded groups is a key feature of neoliberalism (Clarke 2008, 141). But, as was the case at least as far back as the Middle Ages, there is always a margin of the population that does not conform, who are rendered abnormal.

Categorizations within this more generally confined population came to be significant. The difference between subsets of populations came to matter. One such instance is the difference between those categorized as mentally abnormal and criminals. Whereas throughout the 1700s there was great indignation that criminals were forced to occupy the same space as those categorized as mentally abnormal, during the 1800s, this concern shifted to the interests of the latter, who were up until then treated the same as prisoners (Foucault 1965, 223). This occurred at the same time as there emerged a medical model of mental abnormality, one where "unreason joins illness" (Foucault 1965, 205). Confinement was employed to manage those categorized as mentally abnormal as one subset of abnormality. However, this was not just one more subset; this was "the residue of all residues" (Foucault 2003, 54). In other words, this was the subset that could not be brought into alignment with the norm. The confinement of this residue "is the moment when madness actually takes possession of confinement, while confinement itself is divested of its other forms of utility" (Foucault 1965, 235). Those categorized as mentally abnormal remained confined because they could not be brought into conformity with the general population. They were the one subset of a larger, previously confined population that could not be returned to society. This begs the question, if many of

those once categorized as mentally abnormal have been 'returned to society,' who are the newly excluded?

Shifting definitions of reason/unreason are entwined with shifting governmentalities. 'Governmentality' denotes the "conducting of conduct" (Miller and Rose 2008, 16). The concept refers to "a system of power which articulated the triangular relationship between sovereignty, discipline and government" (Turner 1997, xiii). These three components interact in the governance of populations. As Foucault observes, government emerged as a problem in the sixteenth century (Foucault 1991a, 87). Whereas theories of sovereignty are concerned with demarcating juridical power from all other facets of power, as an "art of government," governmentality is concerned with a continuity flowing throughout all of these previously disjointed aspects of power (Foucault 1991a, 91). Taken together, these aspects are entwined in the governance of populations. Most importantly, governmentality calls into question the importance placed upon a unified sovereign, and is more concerned with subtle operations of governance geared towards the population as a species. As Foucault argues, "maybe what is really important for our modernity – that is, for our present – is not so much the *étatisation* of society, as the 'governmentalization' of the State" (Foucault 1991a, 103, italics in original). Governance is not centred upon the State, but involves a range of institutions informed by specific discourses and processes running throughout society. This 'range of institutions' is characteristic of the most recent shift in discourses surrounding community.

At the same time that definitions of mental abnormality have shifted over time, understandings of community have shifted as well. The confinement of those categorized as mentally abnormal to asylums, wherein they are located outside of liberalism's 'world of walls' (Walzer 2007), is done out of protection over the community. This portrays community as a unified whole, one that must be governed by a unified sovereign. The rights-based discourse contained within the idea of a 'shared fate', characteristic of social liberalism, reflects an understanding of a community unified by a common interest, and a sense of mutual responsibility. However, this notion of community has shifted. Neoliberal governmentality calls into question the idea of a homogeneous community governed by a unified sovereign. We are no longer governed by a sovereign as part of a single community; we are governed *through* communities, and more specifically, through our belonging to them (Miller and Rose 2008, 88).

Miller and Rose present this as "the re-figuring of the territory of government in terms of community" (2008, 90). They outline three characteristics of this re-figuration: first, this re-figuration is spatial, in the sense that it is detotalizing; second, it has a "changed ethical character" characterized by a strong sense of personal responsibility to be a good member of one's community; third, there is a particular "role of identification," where communities can only be imagined due to one's personal identification with them (Miller and Rose 2008, 90-91). Taken as a whole, these features are characteristic of what Rose highlights as a "Third Way" of governance: "the Third Way aspires to a contract between those who exercise power and those who are obliged to be its subjects. Although the former must provide the conditions of the good life, the latter must deserve to inhabit it by building strong communities and exercising active responsible citizenship" (Rose 2000, 1397-8). It is up to those categorized as mentally abnormal to be responsible and resilient.

The figure of the responsible, resilient subject is located within a broader neoliberal governmentality. Popular usage denotes neoliberalism as "a radically free market" (Brown 2005, 38). However, it is much more than this. It is an entire political rationality: "Neoliberal rationality, while foregrounding the market, is not only or even primarily focused on the

economy; it involves *extending and disseminating market values to all institutions and social action*, even as the market itself remains a distinctive player" (Brown 2005, 39-40, italics in original). Market rationalities enter into what were previously understood to be non-market domains, such as education and health (Miller and Rose 2008, 18). As Burchell puts it, it includes "the generalization of an enterprise form to *all* forms of conduct" (Burchell 1996, 28-9, italics in original).

Brown identifies four central characteristics of neoliberalism: first, this market rationality permeates every facet of society; second, contrary to classical liberalism, market mechanisms are not natural, but must be guaranteed; third, neoliberalism corresponds to a particular neoliberal subject – rational, cost-calculating, strategizing, and responsible for one's own actions; fourth, a transformation in social policy structured around this economic rationality (Brown 2005, 40-4). It is this third characteristic that shines through in current mental health policy, as evidenced in the literature review centred on individual recovery and resilience. This marks quite an interesting shift in the management of those categorized as mentally abnormal.

Neoliberal governmentality corresponds to a particular subject. It is a responsible, cost-calculating, rational subject. Government interference is limited on the basis that the subject is rational and self-governing (Burchell 1996, 23-24). As Petersen notes, "neoliberalism is a form of rule which involves creating a sphere of freedom for subjects so that they are able to exercise a *regulated* autonomy" (Petersen 1997, 194, emphasis added). It demands that the subject "enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement" (Petersen 1997, 194). Management of the population strives "to maximize the returns on doing what is profitable and to marginalize the unprofitable" (Castel 1991, 294). Above all, different "social destines" are assigned to individuals on the basis of how they fare in light of "the requirements of competitiveness and profitability" (Castel 1991, 294).

Neoliberalism is characterized by individualization. Individualization refers to two phenomena: first, the breaking down of what were once central social categories, such as family and class; second, a new series of demands placed upon individuals to chart their own course as individuals (Beck and Beck-Gernsheim 2002, 2). Individuals must find biographical solutions to what were once social problems (Beck and Beck-Gernsheim 2002, 2). Or in this case, individuals must find biographical solutions to medical problems. Whereas mental abnormality was once a social problem requiring confinement, now those diagnosed with mental illness must find their own individual solutions to living with mental illness. The subject must adjust to an ever-changing society, and be resilient whilst doing so:

> Individualization is a compulsion, albeit a paradoxical one, to create, to stage manage, not only one's own biography but the bonds and networks surrounding it and to do this amid changing preferences and at successive stages of life, while constantly adapting to the conditions of the labour market, the education system, the welfare state and so on (Beck and Beck-Gernsheim 2002, 4).

While their environment is constantly in flux, it is up to individuals to find their own solutions, without the assistance of social analysis or collective interventions. Therefore, modern society may be defined by a degree of "inalienable freedom," but this freedom is in turn entwined with a personal responsibility for success and failure (Beck and Beck-Gernsheim 2002, 7).

Individualization is occurring at a time of what Bauman terms 'liquid modernity.' As a project, modernity was dedicated to 'melting the solids' "of the fetters and manacles rightly or

wrongly suspected of limiting the individual freedom to choose and to act" (Bauman 2000, 5). We are at a juncture wherein these solids have been melted, to the extent that there is no permanent order to fit ourselves into (Bauman 2000, 6). As Bauman explains, "ours is, as a result, an individualized, privatized version of modernity, with the burden of pattern-weaving and the responsibility for failure falling primarily on the individual's shoulders" (2000, 8). There is no longer a permanent order or system to rely upon. This means that "traveling light […] is now the asset of power" (Bauman 2000, 13). Individuals must be able to swiftly negotiate ever-changing situations on their own.

Bauman suggests that 'liquid modernity' corresponds to a 'liquid life' (2005, 1). The predicament is that everyone is expected to be an individual "in a society of individuals." The contradiction as Bauman rightly points out is that "they are […] strikingly *like* each other in that they must follow the same life strategy and use shared – commonly recognizable and legible – tokens to convince others that they are doing so. In the question of individuality, there is no individual choice" (Bauman 2005, 16, italics in original). Everyone must be an individual in a society where everyone is trying to do the same thing, a task Bauman says is "impossible to fulfill" (2005, 18). At the same time, people have different capacities to adapt to this world. Everyone is left to fare for themselves. Neoliberalism privileges a particular subject. Clarke informs us that the inclusion of previously excluded groups is indicative of the notion of personhood characteristic of neoliberalism, one that "works on a model of the self-possessed and self-possessing independent individual, borrowed from the white adult male figure so central to the original formations of liberalism […]" (Clarke 2008, 141). Previously excluded categorizations of mental abnormality are now included. But, this is conditional upon responsible citizenship. It is now up to the individual to find the best solution possible to living with mental illness.

Conclusion

The governance of those categorized as mentally ill is not a new problem. But, it is being problematized in new ways. While much literature exists surrounding recovery and resilience-based models, little discussion surrounds the individualization at the centre of these models, and moreover, what this individualization tells us about the broader neoliberal rationality with which it is entwined. This rationality is dependent upon those categorized as mentally abnormal assuming individual responsibility for their own fate. However, this governance strategy is contradictory, effectively prescribing individualized solutions for social problems. At a time when incidences of mental 'illness' are increasing while the resources to treat them are becoming scarcer, the question of how best to manage populations of those categorized as mentally abnormal is an important one. We have responded to this predicament by putting responsibility for this management upon their own shoulders. This is entwined with the characteristically neoliberal process of individualization.

Now more than ever, individuals are being pressed to find their own solutions to what were once social problems. Indicative of a fatalist attitude, we have accepted that mental 'illness' will never be 'cured.' Rather, we have left it up to the individual to be resilient and to live *their* best life possible. We expect individualized solutions to social problems (Beck and Beck-Gernsheim 2002). This is not progressive mental health policy. Rather, it is one more strategy to take the focus off of a failing neoliberal state by downloading a shared responsibility for those categorized as mentally abnormal onto their own shoulders. When one's fate depends upon his or her ability to swim, or else sink, this can push the fine line between autonomy and cruelty.

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