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Aspects of NISA's Recovery Model: Free Space; Consumer-run/Client Centeredness; Self-Driven Occupational Development

In the face of asylum closures, the reliance on tertiary mental health services has increased, yet funding and research remain inadequate. The problems of mental health reform in Canada are numerous; some would claim that they are insurmountable. It is true that anti-psychiatry and deinstitutionalization have their own problems, yet as Foucault reminds us in an interview: "that does not mean that we were not right to criticize those mental hospitals. I think it was good to do that, because *they* were the danger. And now it's quite clear that the danger has changed" (Foucault *Afterword*, 232). NISA is a non-profit community mental health organization in Sudbury, Ontario. They offer a client-centered, consumer-run recovery service for mental health consumers. NISA tends to many of the problems introduced by deinstitutionalization; moreover, it gives us a working case study of an organization which developed as result of a congregation of a group of consumers and one occupational therapist. What resulted was a model that reflects directly the experience of those who were getting inadequate care; its goal was to develop a working solution for consumer's unmet needs within the community. What interested me about NISA is its untraditional mode of operation. It seems its recovery model goes a long way in distancing the consumer from the power of the medical institution and discourse. In doing so, their model offers the consumer a liberating *space* in which he[*she*] can develop into a complete, unqualified human being. Following some methodological considerations and a brief example, I will describe how NISA effectively circumvents some of the problems of the medical

model. The main area of focus will be the importance of space, the importance of a client-centered recovery model, the benefits of a consumer-run organization, and lastly, NISA's occupational-based services.

Method: Heidegger and Foucault

Heidegger and Foucault would both agree that practices “free objects and subjects by setting up what Heidegger calls ‘clearing’, in which only certain objects, subjects, or possibilities for actions can be identified and individuated” (Dreyfus, Rabinow, & Foucault, 79). Heidegger defines clearing as “free openness...a ‘primal phenomenon’ [*Urphanomen*]...the clearing, sets us the task of learning from it while questioning it, that is, of letting it say something to us” (Heidegger *Basic Writings*, 442). Heidegger sees in the use of language, the “key” to clearing old ways of thinking and new ways of dwelling (or Being). However, Foucault rejects that “in order to study linguistic practices one must take into account the background of shared practices” (Dreyfus, Rabinow, & Foucault, 57). His method does not need to posit an individual (in society) in order to remain intelligible, nor does it ground the meaning of words in shared practices. Rather, Foucault focuses on discursive practices as they mark the parameters of possible truth statements in a given system.¹ Foucault steps outside of the disciplines in order to make them the subject of his analytics; conversely, Heidegger looks for *lost* meanings or understandings from within. Dreyfus reminds us that “Foucault held the chair of the history of systems of thought... [and that] he cannot deal with thoughts and practices when they are not systematically interrelated” (Dreyfus, Rabinow, & Foucault, 261). This gives him a unique perspective from

¹ Foucault was in fact, quite fond of Heidegger's works. In terms of the subjects relationship to truth statements he says: “I have tried to reflect on all this from the side of Heidegger and starting from Heidegger” (Foucault *Hermeneutics*, 189). Heidegger looks at how the definition of *Techne* in western philosophy has led to a “forgetting of Being”; however, Foucault would rather ask the question “on the basis of what tekhnai was the western subject formed” (*Hermeneutics*, 523). There is no *forgetting of Being*, for Foucault, but only of a changing relationship of subject to truth within changing discourse at any particular time in history.

which to interpret the rules of formation and knowledge/power in the development of disciplines; however, “the very strengths of Foucault’s method also define its limits” (Dreyfus, Rabinow, & Foucault, 261). His method uncovers the *dangers* inherent in systems of thought with the purpose of “creat[ing] a history of the different modes by which, in our culture, human beings are made subjects” (Rabinow 7). This analysis will be central to the *problematic* surrounding medical discourse and the psychiatric subject.

For Foucault, one of the greatest dangers that arose from Cartesian thought was the *objectivising* of the human being. In Descartes, as in science generally, there has been a making of objects—a perspective of the experiential world as objects of study. Foucault shows us the dangers of this transition, namely, to make the human beings into objects of study. What follows is a both a system of governmentality (e.g. *The Hermeneutics of the Subject*, *The Birth of Biopolitics*) and of observation/objectivization (e.g. *Madness and Civilization*, *Birth of the Clinic*, *Discipline and Punish*).² Heidegger saw a similar problem within technology. He foresaw that making human beings as present-at-hand (observation, object of inquiry, scientific study), and then ready-to-hand (object of governmentality, individual as a *means to an end*) would lead to a “total ordering of all beings” (Dreyfus, Rabinow, & Foucault, 264). Technology is understood here as united in the old definition of the Latin word “*instrumentum*” which contains both the following criteria: technology as a “means to an end” and as “human activity” (Heidegger *Basic Writings*, 312).

Psychiatry is a technology whose end is the healing of mental disease, and whose knowledge is contained within the doctor as expert. Foucault gives us a systematic study of the

² For Foucault, Power “can in no way be considered either as a principle in itself, or as having explanatory value which functions from the outset” (Foucault *Biopolitics*, 186). Power “designate[s] a domain of relations...governmentality, that is to say, the way in which one conducts the conduct of men, is no more than a proposed analytical grid for these relations of power” (*Biopolitics*, 186). Governmentality, for our purpose, designates the ways in which medical-psychiatric doctors conduct the conduct of the mental health consumer.

development of the scientific-medical discourse which made the psychiatric subject an object of its knowledge and an analytic of the mechanisms and that make up the technology of psychiatry. Heidegger and Foucault would also agree with the problematic inherent in Descartes and the subsequent development of a science of man. What Heidegger adds, though, is the possibility that there is more to the self than the present-at-hand and the ready-to-hand; these are simply attitudes that beings take towards the world. For Heidegger the human being is a coping being; this is a fundamental structure of *Dasein*. This differs from Foucault insofar as it posits a *human entity* irreducible to subject or object, and of an always engaged *Dasein Being-in-the-world*.³ Fundamentally, when the psychiatric patient is made an object of “medical” knowledge, he is positioned in society as dysfunctional, disordered, or ill. This individual, with his way of Being-in-the-world, with its particular teleology and ways of coping is reduced to something less than fully human. Ill and healthy, normal and abnormal, high functioning and low functioning are discursive categories that serve to depersonalize the individual. Moreover, these individuals are thrown into a situation in which they must find a socially recognized style of coping. Foucault calls this “dividing practices” and “subjectification” which “can be effectively combined, although they are analytically distinguishable” (Rabinow 11). Dividing practices are the disciplinary⁴ mechanisms that serve to segregate an individual from society, such as *the great confinement*, asylums, hospitalization, and psychiatric treatment generally; while subjectification is the “way a human being turns him- or herself into a subject” (11). On this latter point, coping is of utmost importance. Society defines a position that the subject may occupy and in which he[she] actively defines him[her]self through a “process of self-understanding...which is

³Heidegger defines *Dasein* as the fundamental structure of human experience. It derives from *Das-Sein*, which means literally *Being-there*. For Heidegger *Dasein* is always immersed in the world; “to say that in existing, *Dasein* is its “there”, is the equivalent to saying that the world is ‘there’; its *Being-there* is *Being-in*” (Heidegger *Being and Time*, 182). The *Being-there* of *Dasein* is disclosed in mood and disposition; while the *Being-in* is disclosed in the experience of the world as ‘understanding’.

⁴Discipline for Foucault is the exertion of disciplinary norms, and regulatory norms on bodies and populations (Foucault *Society*, 253). He later extrapolates this to ‘disciplines’ in the form of subjugated knowledges.

mediated by an external authority figure, be he confessor or psychoanalyst” (Rabinow 11). As coping beings, we are also being-with-others. Our roles are defined by discourse (which gives us the contours of possible practices and self-care techniques) and by our disposition to coping with the existential thrownness⁵ in society. These avenues are heavily influenced by those authority figures that we encounter. The psychiatrist, or medical model practitioner, is placed in a position of authority where his statements are validated by a science; the doctor divides, categorizes, and problematizes ways of Being and seeks to normalize the psychiatric individual. Essentially, one is thrown into the world, and develops ways of coping that bring meaning to one’s existence. Moreover, one does this in the context of an external social system of technologies and mechanisms of governmentality which predefine one’s subject-position. The task NISA must undertake is to provide avenues free of the disciplinary (psychiatric) mechanisms that impede the development of *possible* meaning. It remains that society has its own inherent disciplinary mechanisms which are not part of the current critique (e.g. legal system, education, police and state). The goal of the psychiatric liberation is to allow those with mental health concerns all the freedoms and avenues of meaning that arise within—what Foucault calls—the greater “community of the governed”.

We can now turn to a special case; that of the soldier. This case will illustrate my synthesis of Foucault’s insights, with the existential dimensions of subject formation. I will then explore to what extent NISA engages or avoids these problems.

Brief Example: Post Traumatic Stress Disorder (PTSD)

One objection that could be raised against *Madness and Civilization* is that Foucault’s insights ‘glorify’ the psychiatric subject since his examples consist largely of artists and creative

⁵ Thrownness is very important for Heidegger’s ontic/ontology of being; it means quite literally the “thrownness of [an] entity into its ‘there’; indeed, it is thrown in such a way that, as Being-in-the-world, it is the ‘there’” (Heidegger *Being and Time*, 174). We are thrown into the world and can never separate ourselves from it—we are thrown into *Dasein* (*Being-there/Being-in*).

madness. These examples, it could be said, do not accurately depict the mentally ill population. It is a legitimate issue to raise; however, I believe the case of the soldier serves to show how Foucault's later insights may inform his earlier ones, and give us a more adequate framework on which to explore the existential dimensions of subject formation, which are important to mental health recovery. This example is significant because it gives us two instances of subjectification, and the existential crisis that occurs due to a loss of meaningful identity.⁶

When an individual joins the military, he[she] is taken from his[her] environment and sent to a secluded, physical space where he[she] undergoes technical and professional training. Foucault reminds us that

By the 18th century the soldier has become something that can be made; out of a formless clay, and inept body, the machine required can be constructed; posture is gradually corrected; a calculated constraint runs slowly through each part of the body, mastering it, making it pliable, ready at all times, turning silently into the automatism of habit; in short one has got rid of the 'peasant' and given him the 'air of a soldier' (*Reader*, 179).

Here Foucault describes how the person is made into an object and is transformed, through normalizing practices, into a soldier.⁷ The individual which is being made into a soldier is

⁶ I will use the words "meaning" and "existential crisis" in a general and unspecified manner. To engage with these concepts within this synthesis would be lengthy and would not contribute to the overall purpose of this argument; as the analysis of NISA will depend on its member's experiences (where meaning and concepts of self are broad and undefined). However, of theoretical significance for this synthesis would be Heidegger's concept of *Being-towards-Death* and the work of Ernest Becker; which, generally speaking, is an interdisciplinary attempt at working out the dynamics of *Being-towards-Death*. Particularly pertinent are Becker's *Birth and Death of Meaning*, *The Denial of Death*, and the fast growing social psychological field of *Terror Management Theory*, which developed as result of Becker's work. Frankl's model was used throughout this paper because his concept of meaning is broad, and it does not violate the assumptions useful to the analysis.

⁷ Normalization is the enforcement of norms; "the norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularize" (Foucault *Society*, 252). For Foucault "medicine is a Power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects" (*Society* 252). The norm is the element that intersects the regulatory and disciplinary. Important for our purposes are the norms surrounding medical knowledge; however, the same applies to this example of the military establishment, as they have the same *structure* of governmentality.

conceptualized as “formless clay” or an “inept body”, and though habit (normalization) is made into a “machine”. In other words, by ceaselessly reinforcing norms, the soldier is *transformed* into a *weapon* (an object or an end) at the hands of a sovereign. The soldier as object dissolves into a normalized whole (member of military personnel) and becomes a willing subject to its rules of conduct.

In the unfortunate event that this soldier goes into conflict (battle), he may experience a traumatic event that spirals his life out of control. The individual is thrown into an environment of extreme stress, with significant uncertainty and real risk of death. This gives rise to significant suffering; there is a physical, mental, and emotional toll to both taking a life and risking one’s own—regardless of training. In many ways, the soldier gains meaning from his participation in this traditional role; it gives him[her] a sense of worth and meaning. When this meaning is taken away the soldier falls into existential crisis and experiences distress or despair. As Frankl says, “a man’s concern, even his despair, over the worthwhileness of life is an *existential distress* but by no means a *mental disease*....I would strictly deny that one’s search for a meaning to his existence, or even his doubt of it, in every case is derived, or results in, any disease” (125). The problem is that the soldier is made into a “machine” but he is not one; essentially, it is by virtue of his[her] ‘humanness’ of his[her] *will to meaning* that existential crisis arises.

When the soldier returns anxious, hypervigilant, irritable, and in some cases, delusional (symptom cluster), we blame a ‘weakness’, a biological disposition, or mental illness—Doctors call this Post Traumatic Stress Disorder. Military psychologists often change the term in order to reframe the problem in changing discourse—shellshock, battle fatigue, combat stress reactions—

these are misguided and failed attempts at dismantling the stigma of PTSD.⁸ With his[her] new diagnostic label, the ‘soldier’ is made into an “object” once more, and becomes a subject of the medical establishment. As Lunt points out, “while the burden of mental illness exists in addition to the dilemma of self, it is not apart from that dilemma. Consumers must address self in mental illness, as well as mental illness in self. It is the self that mental illness affects (and effects)” (*quoted in Fardella 115*). Medical psychiatry, with its exclusive focus on treatment, only tends to the symptoms that surface as result of trauma—forgetting altogether the work of recovering one’s sense of self and meaning.

The entity who participates in his subjectification, and for whom the external power of disciplinary institutions bears upon, is a living experiencing human *Being-in-the-world*—with a conscience, a concept of self, and the possibility of suffering. These dimensions of meaning are not present in Foucault; however, it is my contention that they are not mutually exclusive, and that a synthesis is both possible and formative. These existential dimensions cannot be ignored in the analysis of NISA’s recovery model.

Deinstitutionalization and NISA

The process of deinstitutionalization is meant to be a transitory period in which “dehospitalization should lead to the implementation of a network of alternatives outside mental hospitals [...] unfortunately, deinstitutionalization was not accompanied by the development of appropriate community services” (Funk). According to Rebeiro, a Sudbury researcher and occupational therapist very much connected to NISA, “the present-day geographical “community” is no longer a meaningful framework of support for psychosocial rehabilitation” (Rebeiro 499). Furthermore, she surveys additional problems facing community organizations

⁸ I say they are unsuccessful because the term changes without significant theoretical improvement (aside from advancements in PTSD research). Outside of military culture, the clinical term post traumatic stress disorder is used, and the others are considered by most to be obsolete and trite.

such as “the systemic hypocrisy of segregating persons with mental illness within the community and perpetuating both social and internalized stigma by “qualifying” clients on the basis of disability and offering underfunded programs, inadequate economic supports, and unconvincing substitutes for meaningful social occupational opportunities” (Rebeiro 499).

NISA developed out of a collection of programs, administered (prior to July 1998) by the *Outpatient Occupational Therapy services of Network North*. According to their own account, the “common objective of these projects was to reanimate consumers, to offer them meaningful and useful activities (or occupations), and to provide a setting for active social recovery rather than passive dependence on community services” (NISA Web). It was also developed with the vision of participating in mental health reforms that seeks “to make deinstitutionalization work, by providing appropriate community supports for consumer/survivors” (NISA web). As well as a place to be, and a place to gather, NISA provides participants with real occupational opportunity. Their programs provide opportunities to gain applicable skills and to participate in the improvement of the community. *Warm Bodies/Warm Hearts* is a sewing program in which members learn to make quilts that are subsequently donated to battered women’s shelters or the homeless. *The Northern Computer Recycling Depot* accepts donated computers and parts and refurbishes them for sale to low-income families and individuals. *The Writer’s Circle* and *Open Minds Quarterly* are consumer-run publications whose purpose is to combat stigma by showing the creativity and intelligence of consumer-survivors. In addition, the *Artists Loft* is a program that provides materials and space for local consumer-artists to practice their trade, and provides space for the display and sale of artwork. Its professional artists also frequently give art instruction in the space provided by NISA. Moreover, the staff is also actively engaged in community mental health reform and participates in the professional mental health community.

NISA does not seclude itself and create a space that is *like a community*; NISA is always by default actively engaged within the community—in these ways it earns its title of “Northern Initiative for Social Action”.

Significance and Importance of Space as Location

In the history Foucault outlines, the places of confinement were already erected before the *mad* came to inhabit them. He tells us:

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in the same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and ‘deranged minds’ would take the part played by the leper...With an altogether new meaning and in a very different culture, the forms would remain (Foucault *Madness*, 7).

These spaces were positioned in society as places of marvel, then places of confinement for bestial and deranged individuals, and finally as places of ‘treatment’. The place of confinement, which changed with culture and discourse, has its beginnings in leprosy. Space as a precondition for dividing practices and subjectification seems to imply, reciprocally, the need for a space in which we can envisage and enact the liberation of the psychiatric subject. The deinstitutionalized population has no place of its own, no place devoid of an impinging sense of existential neglect.

The term ‘space’, according to Heidegger, has a neglected significance. He aims to show us that “only things that are locations...allow for spaces” (Heidegger *Thought*, 152). He points us to the ancient meaning of “the word for space, *Raum*, *Rum*,” which “means a place cleared or freed for settlement and lodging. A space is something that has been made room for, something that is cleared and free, namely within the boundary, Greek *Peras*” (152). A space is not a “nothing” as we would intuitively think (namely the absence of matter). Space, as it is

experienced, is always a setting of boundaries, a something for *Dasein*. This boundary is, again, not understood as it is in its current use; “as the Greeks recognized, the boundary is that from which something *begins its presencing*” (152). The boundaries mark the *beginning* or *condition* for the existence of a location. In Heidegger’s words: “space is in essence that for which room has been made, that which is let into its bounds...that for which room has been made is always granted and hence is joined, that is, gathered, by virtue of a location” (*Thought*, 152). The room that is made is granted, by virtue of its being cleared. Boundaries set the conditions of *beginning* and becomes a “location”; as Heidegger concludes “*spaces receive their being from locations and not from “space”*” (*Thought* 152, *his emphasis*).

Spaces, e.g. social places, treatment places, places of confinement, are not simply space, but spaces as locations. It is only by virtue of *locations* that places can have meaning that can be appropriated and influenced by social discourse. The clearing of space and the making of locations is the way in which human beings dwell. For Heidegger, “something is concealed in [*bauen*], namely, dwelling is not experienced as man’s being; dwelling is never thought of as the basic character of human being...the old word *bauen*, to which *bin* belongs, answers: *ich bin, du bist*, mean: I dwell, you dwell...the manner in which we humans *are* on the earth, is *Buan*, dwelling” (Heidegger *Thought*, 145-6). Essentially, “to be a human being means to be on earth as a mortal; it means to dwell” (145). Moreover, “this word *Bauen...also* means at the same time to cherish and protect, to preserve and care for” (Heidegger *Thought*, 145). As Rebeiro explains space [as location] “can be interpreted as providing participants with a place to transform being into belonging: It provides a social, material recognition of being and becomes part of the physical matrix of belonging” (497).

Our initial condition, as dwellers, is one of cultivating (of bringing things into being), of coping with *Being-in-the-world*, and of being with others. Spaces provide for locations in which human beings can dwell. Those places only become meaningful when they are within and not segregated from society—when they are ‘part of the social fabric’ (or “physical matrix of belonging”). It is absolutely crucial to have a space outside the conventional mental health system. NISA is a place where one can gain a social existence in a community of others. Bev tells us that “NISA is one of my safe places when being with me is not...I had a childhood where I felt I didn’t belong. I didn’t have a voice. That does a lot of damage; I feel I belong here more than I do with my own family” (Rebeiro 497). This is a crucial factor (as Rebeiro discovered) in clients’ decisions to participate, namely, to have an “environment that is physically and emotionally safe” (497) where they are free to participate in communal or social action—to belong *somewhere*. As human beings we also find meaning in encounters with people, and social relationships. This was made explicit in research interviews with client; “Participants stated that private space is necessary when addressing being needs, but the opportunity to visit others and to meet in more public spaces was important to addressing their social needs, for helping to form a group identity, and for meeting belonging needs” (497). The next section will explore how NISA uses this space, and why it gives us a particularly appealing model for psychosocial rehabilitation.

Consumer-Run, Client-Centered Recovery Model

To be truly client-centered means not to impose one’s opinions about life or health onto the client. It requires one to listen to the client, and to allow him/her to develop a recovery plan which is co-operatively agreeable—without burden of proof.⁹ If we are to avoid coercion, and to

⁹ I simply mean here, that at the stage of recovery, the client should be free to explore all avenues of healing they find appropriate without having to justify his[her] actions (i.e. it must not be part of the regime of veridiction in medical discourse).

allow for truly free and authentic subject formation, all change must reside within the client. The process of recovery must provide a space to legitimize the authentic humanness of the consumer. As presented by Deegan:

The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. The philosopher Martin Heidegger said that to be human means to be a question in search of an answer. Those of us who have been labelled with mental illness are not *de facto* excused from this most fundamental task of becoming human. In fact, because many of us have experienced our lives and dreams shattering in the wake of mental illness, one of the most fundamental challenges that faces us is to ask, who can I become and why should I say yes to life? (*quoted from Barker 98*).

The condition of *recovery* in the sense that I use it here, is one where there is no burden of proof—where the consumer has the freedom to define his own worldview, a basic right we *all* possess. NISA is (and must be) in this way radically anti-normalization. Everywhere, the psychiatric subject carries his label, his subject formation and his subject position. NISA then presents itself as a disconnection. It is a place where people can gather, socialize, learn and develop as full and complete “unqualified” human beings (being needs)—with opportunity for *real and meaningful* social action (belonging needs).

Its status as Consumer-run helps NISA create a place that is not only physically separate from the medical establishment, but is also separate from its sphere of influence. In a very significant way, being consumer-run avoids the problem of the objectivising of the subject that

marks the technology of psychiatry (Ill/healthy, doctor/patient, symptom/treatment, and other such binaries). This problem was mentioned in the first part of the essay.

Medical establishments are made up of four basic levels: (a) the science of medicine (the site of veridiction¹⁰), (b) the institution or infrastructural element (e.g. asylum, hospital, community home) (c) the practitioner (who's authority is granted by the whole of the medical establishment), and finally (d) the patient as object of observation and treatment. Fundamentally, the science of medical psychiatry makes the human being, his brain, and his ways of being, objects of study and manipulation (treatment). It builds a system of empirically validated clinical observation, consequently, developing interventions or treatments that are themselves in turn validated. These treatments having been developed within the framework of empirical science are validated and subsequently integrated within the medical model as the site of veridiction for psychiatric discourse and practice. The physical infrastructure (i.e., what used to be the asylum, and now, the hospital wing) is a *location* where the patient is an object in the hands of the psychiatrist (what Foucault calls dividing practices). This psychiatrist has the authority, granted to him through education and licensing, to propose and enforce treatment regimes (the authority figure that directs the patient in his[her] subjectification). Finally, the patient, who is experiencing some problem for which help is needed, is induced to (and participates in) the belief that he[she] is "Ill", and that the doctor is the only means to a better quality of life.

I do not want to critique this entire model of treatment, which is the work of anti-psychiatry. However, there is something dehumanizing about this model. The individual is made into an object, and his[her] sense of self/meaning is threatened (as seen in the PTSD example, and Deegan's statement). The recovery model, as it is employed by NISA, only seeks to claim

¹⁰ Veridiction is translated by Burchell from the French *Véridiction*; it is, for Foucault, the "set of rules enabling one to establish which statement in a given discourse can be described as true or false" (Foucault *Biopolitics*, 34).

that there is a missing link—the recovery that follows treatment. The recovery model does not reject “the benefits of medical and/or professional interventions. However, from the perspective of the recovery model, medical/professional interventions in the field of mental health, even when necessary, do not represent a sufficient condition for the healthy revival by the subject of herself” (Fardella 117). The recovery model does not in fact *deny* the legitimacy or utility of psychiatry—setting it apart from anti-psychiatry—it simply denies its position as necessary and sufficient for the recovery from ‘problems in living’. The recovery model “promotes a practice of self-care which emphasizes the ethical and therapeutic necessity of including individual/client participation in the process of both defining and actualizing the conditions most conducive for recovery” (Fardella 112). Respect for individual’s agency is essential to the recovery model.

In addition to being Client-Centered, NISA’s structural elements differ from the hospital setting in significant ways. All decisions—budgetary, operational, staffing—are co-operatively made in monthly members meetings, and decisions are overseen and approved by a board of members who are also consumers. Intake interviews, recovery plans, and program delivery are all consumer-run and client-centered. This effectively severs the coercive power that was once found in the asylum, and whose authority is carried on by the medical practitioner. One of Foucault’s most critical points in *Madness and Civilization* is what has since frequently been called ‘the Myth of Pinel’. The *mad* were ‘liberated’ from their physical detainments in a glorious moment of philanthropy; however, those physical shackles were exchanged for moral shackles, where patients were effectively coerced into a normalized subject position. It seems as though the combination of client-centeredness (as opposed to passive recipient) and consumer-run practices (as opposed to professional-run) found at NISA effectively neutralizes the disciplinary power of the medical model of treatment, thereby creating a space conducive to

recovery of the self. In her research Rebeiro has found that NISA members “have had a “rebirth experience” with respect to their illness and identity. Members suggested that this internal process was very personal and hard to describe”; as a member says: “I’ve always felt like I had to prove myself, and here I don’t have to do that. I can be myself...I can discover myself” (Rebeiro 496-7). By giving clients the freedom to explore their value in a consumer-run environment, the NISA model may represent the successful *liberation* that was, before, just a myth.

Self-Driven Occupation Services

If we are to remain close to Foucault’s *Madness and Civilization* we must attend to this question of work. During *the Great Confinement*, “madness was perceived through a condemnation of idleness... [the institution] will have not only the aspect of a forced labor camp, but also that of a moral institution responsible for punishing, for correcting a certain moral ‘abeyance’...it is in this context that the obligation to work assumes its meaning as both ethical exercise and moral guarantee” (Foucault *Madness*, 58-9). He tells us how “in the classical period, indigence, laziness, vice, and madness mingled in an equal guilt within unreason” (*Reader*, 259). There was at this time a certain logic that people were to be productive *for* the state—an idea that culminated in the condemnation of idleness as moral transgression. This entails that the state, by default, has the position of ‘damage control’ with regards to the psychiatric subject (and the ‘disabled’ in general). Through “the relationship of the imperatives of labor to the needs of production” (Foucault *Reader*, 277), and the moral dimensions of idleness (*Madness*, 54), forced labour presented itself as justified by the state. The detainee “was taken in charge, at the expense of the nation”, that is to say, he “had the right to be fed...but at the cost of his individual liberty”; moreover, “he[she] must accept the physical and moral constraints

of confinement” (Foucault *Madness*, 48). Labour was *owed* to the state to offset the costs of whatever form of disability, illness, or problem experienced by any given population. NISA provides occupation based support for its members, but we should be wary that it may carry on the moral condemnation of idleness and thus turn itself into another state mechanism for the reabsorption of the unemployed into the general system of production.

Essentially, “participants are told that they do not have to come to NISA, and if they do, they can come as often or as little as they want. Additionally, their participation is self-directed; they determine what they will participate in and at what level” (Rebeiro 497). In this sense they are *physically* free to self-determine their occupational goals. It remains that there may be a *moral* coercion, that of guilt for idleness; however, it seems that this is not the case. In fact, “Participants spoke about the limited opportunity for occupation within the community that was personally meaningful and held social value” (497). As human beings in society “personal identity is based largely on occupation and economic activity...thus, participants’ becoming needs are driven by a lack of opportunity elsewhere in the community as an aspect of personal fulfilment, and by the implicit questions of who am I and what can I do in this life?” (497). As Frankl reminds us, human beings find meaning in *doing things*, by producing things and accomplishing tasks (133). Self-determined occupational opportunity is conceptualized by NISA as an essential feature of recovery. Two clients had this to say about their occupational participation: “I like what I’m seeing in myself. I think I started becoming who I was supposed to be—just me. Before I didn’t have a sense of purpose and that was leading to death, an inner death” and “the stuff that I do here meant something. It was an important task, I had something to call my own, and that gave me my own strength” (Rebeiro 497). Unavailable to the institutionalized population, work in the community is a way of finding meaning, and of

spending one's time on purposeful action. What is important for NISA is that occupational opportunities are freely chosen, and that participation is completely self-driven. It was assumed in the past that this population was lazy and unmotivated, and therefore, work needed to be coerced; these unfounded judgements served as justification for some of the human rights violations in the history of asylums. What NISA and other organizations show is that the economic difficulties face by this population is due to lack of opportunity, when given a chance, clients show a great deal of motivation and ability.

Poverty is one of the biggest problems facing this population of clients. Many express a need for occupation not provided within the community; however, some do risk losing their disability claims. Many consumers “discover that their attempts to participate in any occupation-based program may jeopardize their basic income security” (Rebeiro 494). For this reason, NISA also offers constant unpaid volunteer occupational and educational opportunities that can lead to better employment opportunities in the community. This second aspect is quite significant. Unlike the history of asylums, NISA's occupational model values personal development over *actual* production—distancing their program from the insistence on economic *production* for the state. Basically, NISA provides the *possibility* of developing one's economic potential, but only to the extent that the consumer wishes to participate. This is an attractive option for those who do not want to lose their disability claims while transitioning (through learning/experience) to a more autonomous economic situation. Concurrently, NISA also implements a three Bs needs model of recovery; for the sake of brevity this aspect of NISA was not explored.¹¹

In conclusion, the advent of deinstitutionalization has led to a large scale shift in the needs of the mental health consumer. The closure of asylums in Canada marks the beginning of a

¹¹ A summary of this model can be found on the NISA website (www.NISA.on.ca) or Rebeiro *et al.* 2001.

new era of psychology (and the Canadian mental health system)—a process inadequately funded and researched. Despite this, NISA managed to develop many interesting and innovative concepts in community mental health. The most important insight is the need for more inclusive (consumer contribution) research and the development of a recovery model that goes beyond the modern system of treatment. More research would have to be done to determine if the aspects I have outlined here are sufficient for the recovery process—and the liberation of the psychiatric subject. That is to say, we would need to establish whether these elements are sufficient for formative recovery, and to determine to what extent these elements can be transferred to other community organizations that employ different models. In any case, it is my opinion that these elements are essential both to NISA's functioning and in avoiding the problems of psychiatric practices outlined by Foucault. Delineated here was: importance of *space as location*, of a non-medical consumer-run recovery model, and of real self-directed occupational opportunity. These factors are essential for recovery and should be further investigated by community mental health researchers.

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