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– ARTICLE –

RECOVERING VOICES IN MENTAL HEALTH

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ABSTRACT

This article builds from research conducted in Tāmaki Makaurau Auckland in 2008, when the Recovery Model was a guiding paradigm in mental health. While ostensibly focussed on individual mental health, the Recovery Model had wider social implications. It was connected to broader moral-political projects, including more integrated forms of partnership between the State and local communities, and greater accountability to obligations and agreements between the State and Māori under Te Tiriti o Waitangi. Post-deinstitutionalisation, mental healthcare developed new moral dimensions, as responsibility for individual well-being was resituated within a more holistic, collective framework implicating all sectors of society. Whānau and families held a central position of responsibility and care within that structure.

Based on ethnographic explorations of carers' relational practices, I explore how families experienced recovery through moments of exchange and encounter at various borderlands. My participants were primarily concerned with whether, and how, familial, treatment, and social exchanges were experienced as considerate, ethical, supportive, and just – more so than they were with medical pathology, symptom alleviation, or medication efficacy. Recovery work for healthcare providers involved creating contexts that were more empowering for commonly marginalised parties, including 'service users', family members, and Māori and other non-Pākehā communities. Families and whānau were tasked with defining and establishing personalised conditions for recovery on a day-to-day basis. Systemic recovery involved a shift from medical power and knowledge to privilege local, cultural, and familial perspectives, strengths, and needs. In this article, I look to participants' deployment of everyday family rituals – including shared kai/food, time and space, gifting, and adornment – as modes of domestic resistance, as well as familial insistence, that can challenge confinements of institutional power.

Keywords: family/whānau; mental healthcare; recovery paradigm; well-being.

INTRODUCTION

This article focusses on mental health recovery for families in Aotearoa New Zealand. It builds from ethnographic research for a master's degree in social anthropology, conducted in Auckland during 2008. Fieldwork included interviews and extensive participant observation at mental health and recovery-related workshops and events, and regular family support groups.

In 2008, the recovery field presented as a network incorporating many voices that contested concepts and practices surrounding mental illness, health, and appropriate care. While the concept of recovery was developing, service users, family members, and carers were encouraged to establish and maintain their own personalised recovery practices. Although their capacity to foster recovery depended on successful engagement within these borderlands, these, in turn, depended on whether they felt their familial values and needs were heard and respected in various exchanges. More than medical pathology, the alleviation of symptoms, or the efficacy of medication, my participants were concerned with whether, and how, familial, treatment, and social exchanges were experienced as considerate, ethical, supportive, and just. As such, for these participants recovery could be conceived of as a moral project, with domestic family and whānau values and knowledge informing and often challenging equally insistent clinical policies, practices, and assumptions. This then is a hopeful essay that seeks to expand and enrich the potential for well-being and recovery within and beyond medicalised borderlands.

THE RECOVERY PARADIGM

The Blueprint for Mental Health (MHC 1998) proposed that individual and social well-being result from people finding fulfilment in respectful, inclusive, equitable relationships in all forms of social encounter. The Mental Health Commission – an independent Crown entity providing system-level oversight – set out guidelines for developing more holistic and responsive strengths-based approaches and services (ibid). The inclusive scope of the Recovery Paradigm's egalitarian discourse proposed 'a whole population approach to mental distress and well-being in which the desired outcomes are for everyone to flourish' (MHAC 2008,14). Mental health providers would recognise and honour obligations under Te Tiriti o Waitangi,[2] and place individuals, family, and whānau at the centre of treatment plans (MHC 1998). Centring on service-user and family needs and strengths, a document outlining Recovery Competencies projected some ambitious ideals:

> [People have] the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). Each person with mental illness needs to define for themselves what 'living well' means to them. The definition of recovery is purposefully a broad one, because the experience of recovery is different for everyone. (O'hagan 2001, 1)

Insistence on greater inclusion of Māori, Pasifika, and other non-Pākehā voices, perspectives, and treatments led to the widespread uptake of Mason Durie's holistic model for well-being, *Te Whare Tapa Whā*[3] (1985). As Durie observed, 'Māori had promoted a personalised approach to health care that many other New Zealanders had intuitively felt necessary, but had not been able to articulate' (Durie 2011a, 30). It seemed that including more diverse input in treatment systems, including Māori models of health, could benefit all within the system.

Around this time, social scientists Larner and Craig (2005) observed new, more inclusive partnerships forming between iwi, NGOs, health providers, local government, and other stakeholders, with household advocates finding new opportunities to influence government policy. Whānau/family and consumer advisors gained permanent roles on district health boards, which led to closer clinical engagement with clients and whānau/family around treatment plans, service design, and implementation (Gawith and Abrams 2006, Thornicroft *et al.* 2013). But as family strengths, skills, and knowledge were mobilised to inform recovery protocols in healthcare and the wider community, systemic inequality, power imbalances, and discrimination were exposed.

To counter discrimination, the Ministry of Health funded anti-stigma campaigns such as Like Minds Like Mine (Thornicroft *et al.* 2013). Once side-lined, first-person accounts of mental illness and recovery entered the broader national consciousness through primetime mass-media advertisements featuring high-profile celebrities. Exposing the widespread prevalence of mental health experience throughout the country, these advertisements expanded the borderlands of mental health and recovery to include the nation (Thornicroft *et al.* 2013).

Informed by global Recovery Movements, local NGOs such as the Hearing Voices Network held events platforming first-person accounts of recovery. These provided opportunities for speakers to take ownership through narrative, while connecting with a wider community (Romme *et al.* 2009, May, Hartley, and Knight 2003). Many of these narratives were emancipatory in tone and context, speaking of engagements with, and resistance to, the medicalisation of personal experience. Questions were raised about the efficacy and appropriateness of international medical conceptions and treatments applied broadly to local indigenous experiences (Webster and Bosmann-Wātene 2003). Some argued that voices of tūpuna or ancestors, and those often attributed to auditory hallucinations, should no longer be subdued or silenced, and represented culturally significant experiences (Randal *et al.* 2009). They linked desires for both personal *and* systemic recovery, challenging some of the force and momentum of mental health institutions and global pharmaceuticals seen as sometimes helpful, sometimes hindering personal growth (O'Hagan 1994, 2001).

Recovery then often involved strong elements of institutional critique. In a guide for carers, mental health recovery educator Caril Cowan suggested parallels between her recovery journey and Paulo Freire's explanation of praxis, involving 'reflection and action directed at the structures to be transformed' (Freire 2005, 126, cited Cowan 2008, 64). She also observed the paradox of resistance, where 'non-compliance with the medical regime is viewed as a lack of insight on the part of the person being treated, which is deemed symptomatic of mental illness' (ibid, 34).[4] Speaking at a Hearing Voices Network event, Mad-pride advocate Arana Pearson lamented that while acknowledging the recovery paradigm in *theory*, his doctor would not remove the diagnosis of schizophrenia from his medical record, despite his being asymptomatic. Like the handle-less door to his room during his first hospital stay, Arana noted the persistent inferences of a system with 'no exit'.

While stories circulated and inspired participants within the NGO and recovery sectors, the movement had limited ability to radically influence medical perspectives or to loosen institutional control on diagnoses and treatment options. Observing how mental health experiences are bound up with the politics of representation within the knowledge-producing landscape, anthropologist Sue Estroff (2004, 288) explained that first-person narratives receive the least funding and page space in medical and academic journals. The flows of influence and effect between differently empowered stakeholders in Aotearoa New Zealand remained uneven (Brunton 2003). This was also true of clinical exchanges. Despite greater inclusivity of service-user, carer, and other diverse voices in treatment implementation, Māori, Pasifika, and other non-Pākehā communities report ongoing and persistent marginalisation (Durie *et al.* 2018).

ENACTING RECOVERY

My methodology was informed by the first-person accounts I encountered the field,[5] and involved enacting a similar-yet-personalised journey of recovery. I engaged with NGOs, participated in regular whānau/family support groups, and attended over twenty workshops, conferences, and related events made freely available in Auckland in 2008. I also conducted face-to-face interviews with fifteen mostly Pākehā participants.

Many within this 'recovery' borderland moved between multiple, often fluid subject positions. As a sometime-carer, I shared various overlapping roles with my participants, including service use and provision, being cared for, advocacy work, and involvement in research initiatives. Like Cowan (2008), we wanted to effect the system, contributing through a relational approach where mind was 'viewed […] as something that "extends beyond the skin" in at least two senses: it is […] socially distributed and it is connected to the notion of mediation' (Geertz 1973, Bateson 1972, cited Wertsch 1991, 14). We practiced what Cheryl Mattingly refers to as 'border work that is politically fraught [and in which] moments of possibility and community are cultivated and cherished across formidable divides' (2010, 39).

Writing about clinical exchanges for black families in the United States, Mattingly (2010) compared medical 'border zones' with frontiers in ethnographies of encounter. Her 'travel stories' concerned 'encounters that have their temporal place within ever larger narrative horizons; they are *historical moments* […] within a colonising history' (ibid, 9). One shortcoming of my project was that with limited scope and time, I engaged with those available within an established field: most were Pākehā and many were women. I noted that my participation in (and the ability to influence) these 'recovering' networks depended on having time, funds, transport, and positive experiences and expectations of inclusion. Several NGO representatives I spoke with noted that non-Pākehā communities were underrepresented at their events and support groups, and that the wider sector was poorer in its lack of diverse inclusion. In this sense, my dissertation perpetuated elements of this uneven representation.

While most identified as Pākehā, my participants' 'border zone travel stories' spoke of wider political struggles and difficulties that can be amplified for Māori in mental health (Durie *et al.* 2018). Their challenges suggested incongruities between some institutional modes of care and more localised domestic practices. Their critique and remedies for these incongruities may stand alongside recent arguments for decolonisation in Aotearoa New Zealand, both in healthcare (Came *et al.* 2020, Durie 2011a) and more universally (Jackson 2020, Kiddle *et al.* 2020). Revisiting these voices now – twelve years after the fact – presents an opportunity to consider how they relate to the long-term trajectory of mental health treatment in Aotearoa New Zealand. As such, I present this discussion as, in part, a historical document in which the ethnographic material 'preserve[s] the future memory of present politics in all its disagreement and incompleteness' (Postero and Elinoff 2019, 21).

Both the Recovery Model and recent conceptualisations of decolonisation infer the need for substantial shifts in power away from centralised governance to locally-empowered social structures – including iwi, hapū, and whānau (Durie *et al.* 2018, Jackson 2020). In the discussion section of this article, I extrapolate from my ethnographic exchanges with Pākehā carers, to wider implications in Māori health. I draw parallels between Recovery ideals, and what Moana Jackson calls 'an ethic of restoration' (2020, 149).[6] While I do not speak for Māori, my hope is that these voices might accompany others demanding more humane and equitable engagements in mental health and beyond (Nelson and Phillips 2018).

I focus on non- or extra-verbal encounters within 'everyday' and domestic and family rituals and routines, as a means of 'getting beyond words' (Estroff 2008).[7] Participants described sticking points where service providers struggled to meet obligations. Hopefully, they also located recovering moments where often-overlooked family needs, strengths, and rituals were recognised and supported in clinical settings. I discuss such recovering moments, both in the home and treatment settings, paying particular attention to the role of context. I put aside medicalised categories to emphasise the relational and intersubjective generation of experience, responding to the research of Desjarlais undertaken at a mental health drop-in centre in Boston. He explains:

> [Where] theoretical and medical formulations fail to account for the intensely felt personal dimensions for human life and suffering […] the emphasis is on felt realities rather than cultural categories, the near rather than the distant, and the sensate over the semantic. The sensate begets immediacy which in turn begets authenticity. (Desjarlais 1996, 72).

Excerpts in the following discussion come from interviews with research participants identifying as Pākehā. One, who I have named Jasmine, identifies as a first-generation Pākehā descendant of refugee settlers. Most are parents in families where someone has been diagnosed as having had one or more psychotic episodes.[8] During the interviews, we developed a mutual ethic of speaking with compassion and care when sharing personal and family information.[9] These discussions continue to inform my research and writing practice to this day. I want to express my ongoing gratitude to my participants for these precious stories.

BEING-AS-FAMILY

I use the term 'being-as-family', suggesting an interplay between identity and enactment. The term refers in part to my participants' stories of solidarity and connection which emphasise both the singular completeness of family and the multiplicity of the individuals within. Family suggests states of being in action that are fluid, inclusive, active, and extend beyond the body to non-human entities including kai or food, adornment, buildings, and gifts. Family sometimes included a wider community of friends and relatives, including ancestors, that were inseparable from the individual, yet often overlooked in medical exchanges.

While first-episode medical assessments and treatment were often experienced as critical moments, recovery involved far more prolonged work for families. Carers navigated a sometimes poorly mapped health system comprising of an array of diagnostic information and other details included in district health board and NGO pamphlets. Where these suggested the possibility of hope and recovery, they provided few specific details of what this meant, how to achieve it, and what support to expect. Like others I met, Rebecca – a woman in her late-twenties living in her parents' home to save money before moving overseas – explained some difficulties 'locating the person' with regards her younger brother:

> Firstly, Alex is a young Kiwi guy who doesn't really know where he's going or what he's doing, but then on top of that he's got his illness, so that's making it doubly hard for him. I felt he was using his illness as an excuse to behave badly. He does do that: 'It's not my fault, it's because of my illness'. And I'm like, 'Your illness didn't make you do that!' Other times he denies he's unwell. But then it's really hard to differentiate between what's his personality and what's the illness, particularly because he was so young when he was diagnosed, you know, he was seventeen or eighteen, so you're really not sure.

Medical models tend to locate illness within the brain and body, suggesting chemical imbalances and prescribing treatment pathways to reduce symptoms. After clinical interventions, participants described the ongoing task of remediating their relationships in mind of new stimulus. For example, they expressed confusion about distinguishing between recovery-related sentiments, directives, legislation, policy, and clinical practices. And, observing their loved ones, they sometimes struggled to differentiate between medicalised notions of illness behaviour, the side effects of medication or self-medication, culturally 'normal' behaviour, stigma and self-stigma, habits, and personality. Where Mattingly notes 'The body itself emerges as a "border territory" in the health encounter' (2010, 12), for my participants, it did so in relation to the home.

Understandings of illness and recovery were often mediated environmentally, through relationships between bodies and the spatial and temporal schema of the house. That is, at a time of flux and indeterminacy regarding the social, emotional, and mental state of individuals and the family, well-being could be assessed in terms of changes and continuities in the ways that people occupied space and place. Home became a central actor in my participants' recovery practice.

The centrality of the house as institution is discussed extensively in anthropology and is evidenced in discussions of the whare tūpuna or ancestral house for Māori (Joyce and Gillespie 2000, Carsten and Hugh-Jones 1995, Treadwell 2017, Brown 2009). Parts of the whare tūpuna are identified with corresponding body parts and the building itself often represents a common ancestor. Panels and carvings trace ancestral lineage, and the structural organisation extends to include cosmological realities and the natural world. Mason Durie's holistic model, *Te Whare Tapa Whā* (1985), integrates the 'four walls' that include spiritual, mental, familial, and economic conditions supporting personal well-being. For Māori, whare incorporate and integrate the corporeal, social, genealogical, and cosmological into a single physical entity that includes those within (Treadwell 2017, Heaton 2015). In this worldview, treatment practice must acknowledge the indivisibility of the person from the wider community (O'Connor 2007). Durie (2007) showed how attending to tikanga – protocols around spatial, physical, and verbal engagement observed on marae – can be helpful to Pākehā clinicians engaging with Māori clients. Similarly, the importance of practicing manaakitanga and the art of hospitality in clinical settings has been outlined in recovery objectives (MHC 1998). While not using the term tikanga, my Pākehā participants articulated similar values and expectations around 'right behaviour' within the house.

Movements inside the home, and time spent in different parts of the house, signalled changes in social dynamics and personal conditions. How space was dis/organised influenced perceptions of, and could be conflated with, a person's condition. Attendance to, or transgressions of, perceived spatial and temporal boundaries suggested permeability between corporeal, spiritual, emotional, social, and material realms. While symptoms and diagnoses factored in recovery, they did so in relation to a holistic condition of being-as-family, and being-at-home, that didn't always register for practitioners within clinical settings.

When their son Peter was treated for a psychotic episode in his late teens, James and his wife Valorie took a caring role, feeling they could provide a safe borderland between Peter and society. However, considering his perceived vulnerability to manipulation, the house and family also became vulnerable. James built their home in the 1970s, materialising their beliefs and hopes, and as such it was part of their being-as-family. As Carsten & Hugh-Jones suggest, 'If people construct houses and make them in their own image, so also do they use these houses and house-images to construct themselves as individuals and groups' (1995, 3). Hearing the details of their 'homemaking', any broad assumptions I held regarding Pākehā subjects being more 'individualistic' relative to others rapidly dissolved. James discussed his sense of emotional relatedness through proximity:

> What I realise is that there is this sort of symbiotic thing happening. The family is like a whole, so with Peter there's something similar taking place, where the frustration that he's experiencing, I am also starting to experience.

James's observation of this interactive atmosphere resonated with other stories of family members' sense of emotional permeability. After crisis – sometimes traumatic, and often involving Compulsory Treatment Orders (CTO) – family members evaluated the relational frameworks through which divisions and connections between people were perceived, challenged, or maintained. For some, recovery work involved re-establishing boundaries around the individual subject and re-assessing the extent and limitations of one's personal responsibilities. Valorie, who went to work each day, was able to maintain a sense of emotional and physical separation. James discussed his experience of doing counselling work from home:

> Because of the accident I wouldn't be able to do terribly much in a week or in a day, and so working from home cut down my commuting time and there was a possibility of giving me something to do, but it's disastrous. Where are the boundaries? Where is the workplace and where is the residence? You know, when people are commuting, the commute is the door; it's how they leave one role and go through to the next . . . and the idea of making a transition, so that you 'the working man' and 'the family man' become more defined. Here we are this morning – [Peter is] sleeping underneath the floor where we're

> talking. There's a consciousness of that. It has influence.

In her ethnographic research with carers, Mattingly observed their 'border work' involving 'moral projects that change shape over time, requiring the development of communities of care, an expanding "we" that brings together an array of people outside the immediate family' (2014, 5). For James, monitoring his emotional condition in relation to Peter's was an ongoing task involving extra-familial engagement, usually at a regular men's group meeting. At the family support groups I attended, the moral implications regarding subjectivity of, and our responsibility for, our individual experiences were enacted contextually. We ritually instated 'sharing circle' rules so that participants felt safe to speak candidly. At a Cognitive Behavioural Therapy for Carers workshop, we monitored, then lowered, our stress levels by tending a sense of personal boundedness. This involved delineating between 'self' and 'other', stimulus, memory, embodied experience, emotions, and thought projections. This practice had a moral dimension: as recovering subjects, we sharpened our perception and beliefs regarding directional flows and limitations of personal obligation, responsibility, and agency. Through these communities, we accessed skills and support, and developed perspective. Also, often needing some distance from the home, we enjoyed a sense of respite.

Back at home, family members discussed how paths toward health or illness might be recognised in the evasion of, or participation in, shared space, time, meals, and conversation. Occupants became acutely aware of the language of the house (Carsten and Hugh-Jones 1995). Open and locked rooms, late-night noise, the use of public and private spaces, lights beneath doors, lapsed or enforced security, undeclared guests, objects moved or missing, smells and foods, running pipes and appliances, clean and dirty dishes, damage and decay – these were some of the voices to which family members responded, emotionally and thoughtfully, establishing an understanding of others and a sense their being-as-family. Anita explained of her adult son who still lived at home:

> There was a time where I'd be pressuring him to be up during the day, and I think initially when he started to be up all night and sleep during the day, I believe that was some sort of opt out. If he lived life like that then there was no sort of pressure. You know, there wasn't anybody around interacting with him and saying, 'you can't do this. You can't be up all night'. I'd get up and find him [dozing] in the morning and say to him, 'Go to your bed downstairs'. And he'd get up and go down there. It makes me wonder why he'd … It's almost as if he wanted to be with us. You know, he didn't want to go downstairs.

Family members reassessed the value and significance of once simple routines and rituals such as eating a meal together. Anita's son's newfound comfort about home, and later making a family meal, were considered recovering moments. His resting in communal areas was both troubling and reassuring: while she ordered him away to sleep in his room, Anita took comfort from his relaxed occupation of family space. As Carsten & Hugh-Jones observe,

> moving in ordered space, the body 'reads' the house which serves as a mnemonic for the embodied person. Through habit and inhabiting, each person builds up a practical mastery of the fundamental schemes of their culture. (1995, 2)

Recovery involved acknowledging new modes of inhabiting space that could challenge previously held values or assumptions as well as the frameworks through which expectations formed. Where concepts of 'mental illness' and 'recovery' were somewhat intangible and inarticulate, signs of ill-health and well-being were inscribed upon the house and observed in changing routines, which involved moral dimensions. The internal bounded spaces of the house might be recruited to mediate and modulate appropriate behaviour, and to assert and exact moral expectations. In this sense, carers often became practiced at clarifying and attending to matters of spatially defined schema around 'correct practice'. Thus, morality, justice, and 'wellness' could be defined and concretised in part by those with power to dictate who and what was acceptable within the house's 'four walls'.

Participants reconsidered once taken-for-granted modes of relating and developed methods for attending to the emotional atmosphere of the home. At another carer-focussed workshop, we worked on broadening our communicative repertoire. Opening windows, cooking, sharing food, taking walks, sitting in quiet space, offering a small gift, a hug, massage, or prayer – these were creative and non-invasive acts that got beyond words while nurturing the possibility of non-confrontational connection.

Like Mattingly's 'first-person virtue ethics' (2014), these iterative, often mundane exchanges constituted a substantial part of recovery. Referring to Iris Murdoch's discussion of moral reorientation, Mattingly explained that 'explicit "efforts of will" are only part of the whole situation' (ibid2014, 84, Murdoch 1970, 56). She observed 'Small moments and routine activities that, at first glance, appear repetitious, pre-reflective, or inconsequential come to take on depth as episodes in unfolding narratives of moral striving and as part of conscious commitments to realise particular versions of the good' (2014, 205). This moral action occurs interpersonally within the home but can also extend outward by way of engagement and critique. In the next section, I describe how, for Jasmine, recovering her being-as-family involved transferring home routines and rituals across and into the borderlands of the health institution.

BEING APART

Where recovery discourse promoted autonomy, respect, and the importance of families maintaining routines (MHAC 2008, O'Hagan 2000a, 2006, MHC 1998), this could be challenging where security and safety were concerned. Like Mattingly's (2014) observations of hospitals and waiting rooms, the forensic ward presented as a borderland incorporating elements of both the 'clinic' and the 'home'. In this section, I discuss Jasmine's attempts to heal her relationship with her son William, who was incarcerated in a secure ward for 'higher-risk' patients. Their struggles highlighted incompatibilities between some clinical policies and participants' family needs. For Jasmine's family, their rituals became powerful, moral acts of resistance affecting personal, familial, and systemic change.

When William entered adulthood, Jasmine insisted that he live away from home so that he would develop, individuate, and 'get a life of his own'. Around that time, he became unwell, was diagnosed with schizophrenia, and remained in an 'intensive treatment' ward for two years. Against Jasmine's appeals, William was released into supported accommodation. Jasmine believed that her intrinsic knowledge of his needs, history, personality, and illness patterns were dismissed – a story I heard more than once from carers. With limited supervision, William ceased taking his medication, became unwell, and after a serious incident of violence, was charged, convicted, and placed in the secure forensic ward. In this position he became 'immobilised', as Jasmine put it, refusing medication, not speaking, nor actively engaging in treatment.

Jasmine found that while they acknowledged government-endorsed Recovery Competencies (O'hagan 2001, MHC 1998), in practice the forensic ward balanced these against public concerns around safety and security (Brunton 2003, O'Hagan 2000b). Patients and family visitors perceived operational and policy inconsistencies as confounding and unjust, but also as signs of vulnerability and permeability in a rigid procedural façade. My participants frequently examined these 'cracks' as opportunities to propose more humane and just treatment possibilities. While maintaining an inflexible posture around a seemingly incidental policy, staff ascribed different functions to the ward. Jasmine explained:

> They used to tell me they were a rehabilitation, or a 'pre-rehabilitation'

> unit, and I just used to say, 'No you're not, you're a prison'. But then the rest of the time when I used to try to tell them they were a rehabilitation unit they'd tell me that they were actually part of the prison service.

Staff had a position of power over patients and, by association, families who were sometimes 'treated as both sick and criminal' (Brunton 2004, 80). Locked rooms, short visiting times made by appointment only, and tight restrictions on exchanges inhibited their being-as-family. Jasmine spoke of seeing visitors travelling long distances by bus only to be turned away if slightly late, and of shift-workers unavailable to attend during regimented Sunday visiting times. Where a receptionist failed to record her appointment, Jasmine was refused entry. After arguing loudly, she explained that 'It was a Māori attendant who saw sense' and bent the rules to allow her in. She expressed concern that where she had time, regular work hours, support, funds, a vehicle, and competence with Pākehā language and bureaucracies, her ongoing struggle to remain close would be amplified many times for others.

For William and Jasmine, the discipline and surveillance that characterised the individual's 'treatment' effectively extended to their being-as-family. Where medication was forced under the Compulsory Treatment and Assessment Act (1992), Jasmine explained that William, subdued and tranquilised, expressed a sense of vulnerability to rape. Safety for the wider community threatened the inverse for patients. Jasmine received a letter stating William would receive Electroconvulsive Therapy (ECT):

> I wrote a three-page letter as to why they weren't going to give him shock treatment. [. . .] It's kind of interesting isn't it: mental health . . . you get a mental health situation like William where you're mentally ill and then you do something and then you become less than a person, a person with no rights, you're actually owned by the state – they can put drugs in you, they can give you shock treatment . . . you are a thing, a body. You are incredibly vulnerable.

International studies showing that ECT and other treatments can be conducted in an effective, painless, and humane manner (Carney *et al.* 2003) fail to account for personal and familial histories, local realities, and cultural contexts. Jasmine's refugee background was intrinsic to her embodied identity, which included ancestors, siblings, and descendants. She spoke of her uncle and mother receiving ECT as discipline and retribution in their homeland. These memories were ingrained within their family being. She felt it necessary to advocate on behalf of William in his mute, vulnerable condition. Sharing in this struggle against the institution, they developed a sense of solidarity and reconciliation – unexpected opportunities for mending their familial relationships.

Where Gawith and Abrams suggested that 'the task of facilitating recovery in partnership with consumers presents an ongoing challenge for mental health professionals [that . . .] may mean a substantial renegotiation of power and privileges' (Gawith and Abrams 2006, 146), Nick Argyle observed that in Aotearoa New Zealand, 'the positive development of consumers, the NGO, and recovery paradigm has unfortunately been accompanied by a pervasive negative attitude to clinicians' (Argyle 2005, 2, *cf.* Gawith and Abrams 2006, 146). Jasmine recognised that under-funded and under-staffed clinical units sometimes struggled to serve clients and meet families' needs. She noted that visitors' outbursts spoke of their sense of a non-responsive, impersonal system. Efforts to remain calm, articulate, and polite were often thwarted while signs of distress and unmasked desperation often begged, and best ensured, attention. However, while non-cooperation was sometimes met with expletive force or coercive treatment, when William's words failed him, Jasmine reverted to kai:

> When William was unwell, and we made a cake, we'd always take a piece down, and if I got a good nurse, she'd let us take it in, because of this idea that this is… what's fundamental to whānau and family relationships is that you eat together, you know. That's communication… these are fundamental things, in any culture. You'd know as an anthropologist you go in there and food is what congeals people together.

'It's communion?' I offered. Jasmine continued,

> Absolutely. And when this boy is so unwell that he can't speak, a piece of cake becomes the point of connection and the communication. But because it's a lockup ward … I used to have to say to them, 'Look, I haven't got a problem. I don't want to compromise your security … for God's sake, do some kind of evaluating thing – don't just have a blanket [policy]'.

Cake presented William with something of the hearth and home, mediating borderlands and reincorporating him back into their being-as-family. Small family rituals presented both symbolic and practical action that might penetrate the physical boundaries of the forensic unit, and the body. Seemingly innocuous to the hospital's agenda, this small, 'common sense' ritual of sharing kai reunited family. When Jasmine referenced the importance of food to whānau-making, she used the cultural resource to make sense of her own situation, and as a means of leverage with staff. She also hoped to push for greater institutional recognition of the importance of Māori whānau strengths and values. However, while not intending to be appropriative,[10] we can see that the resources she drew upon were extensive, and question how their efficacy might have depended on her status as a highly educated, articulate white woman.

Nearing William's birthday, his family turned to gifting to engage and generate shared well-being. Jasmine and his sisters bought William some locally made clothing.

> They said I couldn't gift William these clothes. I said, 'Look, I'm quite happy – I respect security, of course I want security . . . I'll give you the clothes, you put them through security, you hold on to them and then give them back to me and you create a situation where I can gift them to William'. Because when someone's hurt you, you need to repair relationships; you have to mend them by gifting. 'These cost me money. I want to gift them to him. I want to look at the excitement in his face. And I also want some culpability, some sense of responsibility. When someone gives you a gift, you know, nothing's free in this world. It's with responsibility. I want him to look after these clothes because they've cost us a lot of money…' Anyway, this was not going to be possible.

After many meetings, Jasmine was eventually permitted to give William the clothes. In recognising the gift, staff acknowledged William's being-as-family – allowing the movement and interplay of objects and bodies in space and place. For family, recovery involved attending to embodied, nurturing, and protective layers: sharing kai, gifting, and adornment. Seeing William dressed well and with dignity was significant to all – including family, staff, other patients, and William himself. Their purely articulate, aesthetic, and locally branded voice spoke to the senses; clothing returned William's body physically into the fabric of family.

Eventually, William gained confidence and found his voice again. He moved to supported accommodation where he could be surrounded by home layers: a desk, paper and pens, and a laptop. For Mother's Day, William recorded a track and sent it to Jasmine. At the end of the interview, I turned off my recorder and Jasmine said, 'I'll play it to you. It's very Eminem.' We listened to William sing about moving 'between cells' in the clothing his family gave him, the Huffer vest worn proudly, close to his heart. Sitting at the family dining table there was something of William present in the room with us.

DISCUSSION

Following deinstitutionalisation accelerating through the 1970s and 80s, the recognition of holistic and indigenous models of well-being in the 1980s and 90s, and the progression of the recovery paradigm through the early 2000s, responsibility for mental healthcare has largely been resituated within the domestic and whānau/family sphere (Gawith and Abrams 2006). Subsequently, diverse stakeholder groups have been coming to terms with challenges of non-/permeability and the limits and potential of their influence within the borderlands of mental health. While the Recovery Model held promise for large-scale change and a more just society, its shortcomings continue to be felt within mental health settings.

While recovery stories circulated and inspired participants within the NGO and recovery sectors, the movement had limited ability to radically influence medical perspectives, or to loosen institutional control on diagnoses and treatment options. But as Cheryl Mattingly (2010) explained, for her black American participants, each clinical encounter presented opportunities to contribute to wider narrative horizons within the history of colonisation. Where institutions seemed rigid and regimented, my participants mobilised small acts of moral resistance and insistence, pitting family values against bureaucratic processes. Thus, in this section, I extrapolate outward from my ethnographic material to discuss how these acts might have implications for wider institutional and political change in Aotearoa New Zealand.

The potential for systemic transformation is explored in Larner and Craig's (2005) discussion of new partnerships between NGOs, iwi, health providers, consumers, family advocates, and policy makers in the late neoliberal era. They observed that the resulting, more locally responsive form of governance in the country 'is not just embedded, it is also feminised and domesticated' (ibid, 406). They suggest that while, in their search for legitimacy, domestic actors are 'bureaucratised' through technocratic engagement, government institutions and policies are, in turn, influenced by domestic moralities. One result is that mental health providers and policy advisors may become more responsive to community needs. However, if early intervention, home-based treatment, and other successful programmes within these borderlands of mental health inform the shaping of recovering subjects, these subjects tend to share much in common with characterisations of vocal, mobilised, proactively engaged neoliberal citizens acquainted with that system (Woolford and Nelund 2013). The mental health system as it prevails today continues to privilege certain voices and replicate conditions and contextual arrangements that preclude others.

More art than science, well-being for my participants was gauged and influenced more through social exchanges and the manners and movements of bodies in place and space, than diagnoses or medical interventions directed toward the cessation of symptoms. In Compulsory Treatment settings, families worked hard and often struggled to maintain small rituals that affirmed their being-as-family. Likewise, particularly where security and safety were concerned, these facilities presented physical, temporal, and procedural barriers to their efforts. Recovery in these borderlands depended largely on stakeholders accessing sufficient resources to develop arts of engagement effective within that specific cultural context. This involved recovering voices – both within and beyond their usual vocal range. Gifting, kai, adornment, shared space, song, touch, and family rituals – all were deployed as means of traversing seemingly impermeable boundaries. These often mundane yet crucial whānau/family practices challenged, and were challenged by, the confinements of institutional power and procedure.

If my Pākehā participants struggled to have their fundamental family needs heard, so too did many Māori. Recent studies reiterate findings from two decades ago showing that Māori and Pacific groups continue to be over-represented in troubling illness and suicide statistics, while feeling unheard and ill-attended in clinical encounters (Durie *et al.* 2006, Durie 2017, Durie *et al.* 2018). Where recovery rhetoric demanded a more responsive whānau/family and consumer-informed approach to care, forensic services presented as an inflexible, semi-permeable, State entity that maintained uni-directional flows of agency and effect. In research sharing first-person patient narratives about the forensic ward, Whetu astutely observes:

> The two systems don't fit together very well – the whānau system and the mental health system […] It's often said that Māori families don't give enough support. But it's because it's not a welcoming atmosphere. (O'Hagan 2000b, 8–9)

Regarding the exclusion of Kaupapa Māori in mental health legislature, Michael Naera explains: 'Whilst it acknowledges that there is a treaty, what they failed to look at is the implementation of that in practice' (cited Olley 2021, 2). Came *et al.* (2020) suggest that where nurtured and supported, indigenous expertise and practitioners in the health system can rise up like ngahere – native bush

– ascending from within to eventually overshadow the intrusive gorse. For Durie and colleagues, honouring Te Tiriti in mental health relationships would involve indigenising the health system. They also suggested a broader shift in governance, where 'responses and solutions reside in the realisation of treaty guarantees and whānau, hapū, and iwi rangatiratanga/self-determination' (2018, 39). Again, holistic well-being infers a shift away from coercive and colonising systems at every level.

Presently in Aotearoa New Zealand, the Recovery Paradigm has largely given way to a model focussed on well-being (Welch 2019) that likewise recognises the need to honour Te Tiriti. When considered holistically and relationally, the borderlands of mental health extend and undulate outward into moral and political terrain beyond the individualised bounds of medical frameworks. As anthropologist Jeff Sissons (1990) suggested thirty years ago, State-directed institutions do not have the financial and structural means, and seek but cannot acquire the legitimacy to adequately respect the whole person in their lifeworld. Perhaps where Pākehā bureaucratic systems fail, long-established socially and historically embedded responsive forms of governance can better ensure obligations to individuals and whānau are met. As Mason Durie (1998, 2011b, Durie *et al.* 2018) insists, supported under treaty settlements, iwi and hapū may be in a better position to do this.

While research and policy directives support Māori voices and needs in spirit – with government agencies drawing on Māori terminology and language to inform departmental name changes and policy documents – implementation in practice has been slow (Waitangi Tribunal 2019, Durie 2019, Came *et al.* 2020). The Māori Health Authority and recent iwi-led treatment options go some way toward addressing this. However, Brunton's observation of mid-twentieth-century institutional care, that the 'lofty policy intentions gave way to the realities of severe socio-political, therapeutic, staff, and capital constraints, as policy ideals were at odds with the practicalities of running an institution' (2004, 75) still apply several decades later. The recovery paradigm's insistence on systemic reform sounded hopeful, but like recovery for individuals and families, the final details and capacity to deliver remain, at times, elusive.

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NOTES

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2 Te Tiriti o Waitangi (1840) – The Treaty of Waitangi – is Aotearoa New Zealand's founding documents, written in Māori and English, and signed by the representative for the Crown and about 540 Māori chiefs.

3 Durie's holistic model of health includes four areas that ensure well-being: Taha tinanan (physical health), Taha wairua (spiritual health), Taha whānau (family health), Taha hinengaro (mental health). This model integrates the mental, social, spiritual, and material/physical elements all crucial for individuals and communities to thrive (Durie 1985).

4 Arana Pearson, a voice hearer with a long history of advocacy work and a strong online presence, often discusses his experience of establishing a personal recovery narrative that responds, challenges, and resists medicalised definitions of his experience.

5 See for example (O'Hagan 2000a, b, MHAC 2008, Leibrich and Adams 1999, Cowan 2008, O'Hagan 1994, Geekie 2013, Peterson 2007, Peterson, Barnes, and Duncan 2008, Peterson 2004, Deegan 1988, Deegan 1996, Clayton 2004, Fenton and Te Koutua 2000).

6 Jackson explains of the idea of decolonisation: 'Perhaps it could be replaced with the ethic of restoration. The use of this term would seek to replace colonisation not by merely deconstructing or culturally sensitising the attitudes and power structures that it has established, but by restoring a kawa that allows for balanced relationships based on the need for iwi and hapū independence upon which any meaningful interdependence must rest' (Jackson 2020, 149).

7 Anthropologist Sue Estroff (2008) expressed this in her keynote address at a

conference for Innovative Approaches in Mental Health Research. This discussion was made available in MP3 format, and can be requested from an online administrator at http://studymore.org.uk/mhhtim.htm#.

8 Where I refer to experiences as 'illness' or 'being unwell', this follows my research participants' usage.

9 Each spoke of the importance of the research context: that we shared out of love, concern and compassion, hoping to affect some good through discussing our experiences. High among my considerations was the assumption that family members might read the thesis. As one of my participants James suggested, I would 'ethically clense' our discussion in my writing, carefully and in alignment with my personal values. Jasmine suggested as we spoke of her son that I could write in ways that were enabling rather than confining, drawing attention to strengths and opening possibilities.

10 Cheryl Mattingly wrote of the potential for stressed and problematic hospital exchanges, but also that 'border encounters in hospitals can lead to imaginative borrowing, syncretic inventiveness, the creation of common ground; they may have their creative and even generous moments' (2010, 12).

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