Situating risks.

Constructing family and whānau consultation - a discourse analysis.

Darren James Mills

A thesis submitted to
Auckland University of Technology
in fulfilment of the requirements for the degree of
Doctor of Philosophy (PhD)

2024

Supervisors:
Katie Palmer du Preez
Joanna Fadyl
Brian McKenna

Abstract

Approximately 10,000 New Zealanders per year experience compulsory assessment and treatment for a mental disorder, leading to possibilities of hospitalisation and other practices mandated under the Mental Health (Compulsory Assessment and Treatment) Act, 1992 [MHA, 1992]. This thesis is concerned with the practice of Section 7A *consultation* occurring between the family and whānau of a person undergoing compulsory assessment and treatment and the responsible clinician overseeing the process under statutory law. Since the 1990s, Aotearoa New Zealand health policy, frameworks and strategic documents have increasingly promoted family and whānau 'inclusion' in mental health service delivery and planning, including compulsory practices, as 'best practice'. However, uptake has been limited; and family and whānau continue to describe stigma and other barriers to inclusion.

No research in Aotearoa New Zealand has focused on exploring the complexity of family and whānau *consultation* and possibilities for future practices. This study aimed to address that gap. A poststructural methodology was used to consider the conditions enabling and restricting family and whānau in past, present, and future iterations of *consultation*.

I chose a Foucauldian genealogical approach for my inquiry to interrogate family and whānau involvement in mental health *consultation* practices. I analysed texts from the 1950s to the present to make visible assumptions and norms underlying contemporary practices through a 'history of the present'. My study has provided a unique insight into how historical representations of family and whānau continue to play out in contemporary practices.

My analysis exposed how early constructions of family as a site for the emergence of mental illness provided the possibilities and limitations for their inclusion in mental health practices. An intersection between responsibility, rights, and the notion of different forms of 'expertise' from the 1980s, characterised family and whānau as support systems. Notions of *consultation* emerged as thinking and practices to promote and assist family and whānau involvement for the successful functioning of *community care.* The integration of *consultation* into the MHA, 1992, in 1999 as Section 7A, embodied European individualistic values. Analysis of contemporary texts identified that greater acknowledgement of Te Ao Māori (world view and cultural practices) in policy has shifted services away from individualistic (*patient* centred) towards collectivistic approaches. However, barriers to *consultation* continue through discursively situating *risks* in family and whānau. The thesis concludes by noting how *consultation* continues to operate as a tool of colonisation. Although functioning to hinder equitable practices, recent shifts in policy provides some hope for more inclusive practices.

Table of Contents

List of Figures

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Darren James Mills

Date: 03/09/2024

Acknowledgements

I was incredibly blessed to have a highly functioning and supportive supervision team from Auckland University of Technology (AUT) that made my journey both doable and pleasant. My sincere thanks to Dr. Katie Palmer du Preez and Associate Professor Joanna Fadyl for advancing my ability to engage in poststructural analysis; enabling me to challenge my reasoning and think outside of boxes. As a team, we were blessed to have the topic expertise of Professor Brian McKenna; his deep understanding of mental health practices opened up this thesis and supported its accessibility. I would also like to acknowledge my first supervisors, Associate Professor Kirk Read and Dr. Deborah Payne, who helped me to narrow down my research topic and endured my early ramblings. Finally, I would like to recognise Professor Elizabeth Smythe whose gift of polished stones on commencing my doctorate journey and weekly emailed photographic musings kept me on task to reach this ending.

I would also like give my heartfelt thanks to Shaz Bryant, Kaitohutohu Ngaio/Professional Advisor - Tangata Whenua to the Board of Occupational Therapy, and Haroma Matthews, for guiding and supporting my appreciation of Te Ao Māori in this beautiful land of Aotearoa. Tihei mauri ora!

My thanks to my parents, Mark and Linda, who provided the foundational values and support to be the person I am today. I am also very blessed to have had the support of the love of my life, my wife, Vani. Her encouragement for me to engage in post-graduate study and ongoing support into the world of academia was an essential factor in completing a PhD. I would also like to thank my son, Sujay, for his patience during my studies; and my daughter, Aria, for continually sharing her love and joy of life—brightening the darker spaces.

To my work colleagues at Otago Polytechnic, thanks for putting up with me, especially Dr. Rita Robinson for her reassurance that being stuck in the ‘mud’ was part of the process, and Dr. Elizabeth Martin for her sense of humour and rallying motivation. I would also like to thank my formal leader Dr. Penelope Kinney who supported my juggling act of work and study. To my other work colleagues in the ‘Crisis Assessment and Home Treatment Team’, thank you for supporting my clinical journey.

Finally, thank you to Shoba Nayar for proofreading and formatting this thesis in compliance with AUT guidelines, and to my examiners for robust feedback.

Chapter One: Introduction to the Research

Family and whānau[1] involvement in compulsory mental health assessment and treatment practices in Aotearoa New Zealand is a complex issue. Since the 1990s, Aotearoa New Zealand and international health policy, frameworks, and strategic documents have increasingly promoted family and whānau inclusion in mental health service delivery and planning. Aotearoa New Zealand policy concerning mental health service provision has called to empower (Ministry of Health, 1994), better respond to (Ministry of Health, 1997), address the needs of (Minister of Health, 2006), increase support for and involve (Ministry of Health, 2012c), and enhance the voice of (Ministry of Health, 2021) family. These policy examples promoting family-inclusive service provision highlight potential limitations experienced by family and whānau and the overall complexity of engaging with family. National reviews of *community care* practices from the 1990s (Mason et al., 1996; Mason, 1988) to the most recent government inquiry (Paterson et al., 2018) suggest that family and whānau inclusion in compulsory assessment and treatment practices is problematic, despite attempts by government to promote and apply 'best practice' principles.

My interest in this inquiry stems from working within a clinical role in a crisis assessment and treatment team. Part of my role includes facilitating legislative practices, including involvement of family and whānau members of persons undergoing compulsory assessment and treatment. Witnessing a lack of consistency in practices enabling and excluding family and whānau in *consultation* practices was the starting point for the development of this thesis.

The purpose of this inquiry was to question the contemporary practice of family and whānau *consultation* under Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act [MHA, 1992] by identifying conditions that have made this practice knowable, thinkable, and possible. My interest in how historical thinking and practices operate in the present led me to choose a Foucauldian discourse analysis methodology. From this methodological position I have been able to analyse how family and whānau

---

[1] Family represents a basic component of social organisation which performs specific roles and responsibilities within the group. In this thesis, family generally represents nuclear units/smaller households of people, such as comprised of parents and children. However, the term also represents non-traditional constructs that have developed in the 20th century to include non-heterosexual and non-biological relationships. Whānau (te reo Māori) refers to giving birth and several understandings that represent or associate with meanings of family. In my thesis, whānau generally represents extended family systems, including hapū (clan) and iwi (tribe) embodying collectivistic and communal forms of relations and living. Deployment of these terms separately or together denotes emphasis or generality.

consultation under Section 7A came about in its current form; to think about what other forms it might be possible to take; and examine the effects of these multiple possibilities on those involved.

This chapter introduces the study and the organisation of the thesis. It begins with an overview of compulsory assessment and treatment in Aotearoa, and practices of *consultation*. The next section outlines my background and interests that led to the study. I then provide a brief historical overview of the response to madness/mental illness in Western society, providing context to the notion of *community care*. This is followed by introducing how my research is situated within a poststructural methodology and, thereby, how the research can be read. I briefly cite some of the aims of international and national research to further situate the importance of this study. I then position myself in relation to the texts I have analysed. Finally, I introduce the thesis structure. From a poststructural position, literature is seen as systems of knowledge that construct and produce itself; therefore, this study does not contain a traditional literature review but treats literature as data for analysis.

Compulsory Assessment and Treatment in Aotearoa

The MHA, 1992 stipulates persons considered to be mentally disordered and a significant danger to their own or others' health and safety, by a psychiatrist, may undergo compulsory assessment and treatment, including hospitalisation, against their will. Approximately 10,000 people in Aotearoa New Zealand per year experience compulsory assessment and treatment for a mental disorder. In the financial year 2021/2022, 11,299 people were subject to the MHA, with 5,975 people subject to compulsory assessment (Ministry of Health, 2023). Statistics from the latest population census (Stats NZ: Tatauranga Aotearoa, 2023) estimates 5.27 million residents in Aotearoa New Zealand year ending 2022, hence 0.21 percent of the population experienced compulsory assessment and treatment in 2021/2022.

The legal framework governing compulsory assessment and treatment, is currently found within the MHA, 1992. In Aotearoa New Zealand, legislation concerned with compulsory assessment and treatment, dates back to the Lunatics Ordinance of 1846 which, based on British frameworks, provided the process for assessment and involuntary admittance of persons into jail or hospital. The emergence of the asylums from the mid-19th century and the shift to large psychiatric hospitals from the beginning of the 20th century became the norm for treatment until deinstitutionalisation practices came into force from the 1970s (Brunton, 2003, 2005). The practice of *consultation* was introduced as an amendment of the MHA, 1992 in 1999, reflecting the general promotion of family involvement in mental health service provision from the 1990s in policy and strategic documents.

Section 7A, in the MHA, 1992, refers specifically to the practice of *consultation* between the *responsible clinician*, normally a consultant psychiatrist, who finalises the outcome of compulsory assessment, and the proposed *patient* or *patient's* family or whānau. *Consultation* has been described in the latest guidelines to the MHA, 1992 (Ministry of Health, 2022a) as

> ongoing engagement between the health professional, responsible clinician (and treating team) and the family or whānau of the patient or proposed patient in a therapeutic process. Consultation is a two-way ongoing process and 'should not be limited to achieving formal obligations'. (p. 43)

According to the Ministry of Health (2022a), *consultation* can occur in person or through other mediums, such as teleconferencing, with the intention to involve family and whānau within decision making processes, enable their contributions to be heard, and alleviate any concerns about information sharing and treatment.

Involvement of family and whānau following the 1999 amendment has remained contentious. Reviews of practices have identified family and whānau *consultation* as problematic citing similar concerns from one review to the next. Recommendations to improve practices have appeared to have little impact on perceptions from family and whānau regarding their inclusion and agency. A range of concerns have been repeatedly made over the years since Section 7A *consultation* appeared in legislation. Examples include a review by the Mental Health Commission (2007) that confidentiality and privacy were inappropriately used to exclude family due to misuse of the Privacy Act 1993. A review of Section 7A by the Ministry of Health (2006), identified *consultation* as best practice but noted a need for training for clinicians and clearer guidelines due to inconsistencies in practices.

The government inquiry into mental health and addiction services 'He Ara Oranga' (Paterson et al., 2018) identified continual inconsistencies in practices and exclusion of family and whānau, including through misuse of privacy. Critique in 'He Ara Oranga' included perceptions from family of marginalisation, isolation, and a lack of agency, similar to themes identified in the Mason et al. (1996) inquiry. My inquiry has addressed these recurring problems through identifying how contemporary practices are contingent on historical knowledge operating in the present; a ‘history of the present’.

Significant critique from Māori on culturally inappropriate service provision has also been a major theme in reviews (Mason et al., 1996; Mason, 1988; Paterson et al., 2018). Health disparities between ethnic populations have increasingly emerged as problematic within policy from the 21st century (Minister of Health, 2023a; Ministry of Health, 2002b, 2014). Rates for Māori accounting 17.8 percent of the country’s population (Stats NZ: Tatauranga Aotearoa, 2023) accounted for 28.4 percent of service users undergoing compulsory assessment and treatment. With Māori 4.0 times more likely than other ethnicities to experience compulsory assessment and treatment (Ministry of Health, 2023) research suggests bias and racism stemming from colonisation as causative of mental health *inequities* for Māori (Cohen, 2014; Cohen, 2020; Curtis et al., 2023; Houkamau et al., 2017; Manuel et al., 2023). The pathologisation of non-Western family practices and *risks* associated with being Māori is explored in my inquiry to make visible how cultural constructs act to constrain and enable Māori whānau inclusion in *consultation*.

The relevance and purpose of this research is twofold. Firstly, *consultation* is represented as positively impacting outcomes for persons experiencing compulsory assessment and treatment, yet remains problematic and contentious (Ministry of Health, 2022a; Paterson et al., 2018). In 2018, the national inquiry into mental health and addiction, ‘He Ara Oranga’ (Paterson et al., 2018), critiqued the MHA, 1992 as outdated and an abuse of human rights, recommending its repeal and replacement. My inquiry provides an analysis on the historical development of *consultation* to identify limitations constraining and enabling present-day *consultation* practices and, thereby, possibilities for other practices that may improve *patient* outcomes. I hope that the arguments developed within this thesis support discussions on future legislation concerning family and whānau *consultation*. Further, my analysis explores *inequities* experienced between Māori and non-Māori family and whānau. I hope that making visible relations between *consultation* and colonisation may lead to more *equitable* practices in the future.

My Background and Interest in the Research

I graduated as an occupational therapist in 1998 in the United Kingdom and started working in the field of mental health in London. In 2001, I became a volunteer for the organisation ‘Voluntary Services Overseas’ based in Eastern Sri Lanka to support the development of community based mental health services. This experience provided my initial interests in the role of family in supporting persons diagnosed with a mental illness contextual to the tensions arising from familial stigma of mental illness and the lack of supports available other than family. I spent the next 9 years working in various roles in Sri Lanka, Cambodia, and The Maldives, in the fields of disaster relief, humanitarian aid, and community development. Living and working in diverse cultural environments expanded and enabled me to question my English worldview and notions, such as individualistic and collectivistic ways of living, and resonated with my passion for occupational justice (equity for persons to engage in meaningful occupations). One common thread throughout my work in Asia was a growing recognition of the conditions limiting and enabling family to engage in specific roles, such as caring, and supporting recovery and wellbeing from illness and disability.

On moving to Aotearoa New Zealand in 2010, I worked within a community mental health team for a district health board, and within the next few years transitioned into roles within triage and then crisis mental health assessment and treatment. An expectation of working in crisis mental health was becoming a duly authorised officer (DAO). In this role, there is a statutory requirement to facilitate certain Sections of the MHA, 1992, including assessment, while acting as a contact point between services and the community, often family and whānau. Within this role I became aware of the tensions and dissonance between policy and guidelines stating ‘best practice’ and actual practices involving family and whānau including *consultation*.

Anecdotal evidence from observations has supported my identification of *consultation* as a contentious issue within service provision. I have witnessed a lack of consistency in practices arising from a myriad of factors impacting the family’s ability to engage and participate in *consultation* as stipulated in guiding documents, such as ‘Guidelines to the mental health (compulsory assessment and treatment) Act, 1992’ (Ministry of Health, 2012a, 2022a).

These factors range from within the family unit itself, such as cultural and educational backgrounds and contextual understandings and perceptions of mental illness. Different understandings of what different behaviours may be or mean, or how they are considered and characterised by the family, provide an initial relationship with clinicians through how knowledge is communicated. Furthermore, ability to articulate concerns incorporating psychiatric terminology can be interpreted as ‘insight’ and congruence with medical understandings and lead to greater or lesser inclusion in decision making.

Other factors relate to the *responsible clinician*, such as their cultural background and understanding of the cultures in Aotearoa New Zealand, including Indigenous perspectives of health. The ability to connect with family and create a relationship of mutual trust can impact the sharing of knowledge, and thereby information that may best support the person experiencing compulsory assessment and treatment. Unconscious and conscious bias from clinicians can lead to different outcomes between Māori and non-Māori, leading to inequitable practices.

Factors relating to the DAO, including myself, such as time available and determination to contact family when contact details are unclear, directly include and exclude family. The confidence to delay proceedings to support family involvement and the ability to connect with family and encourage participation if needed, can impact decision making by the *responsible clinician*.

Finally, factors relating to the person undergoing assessment, including their thoughts and wishes on family involvement, and ability to contact or supply contact details if not documented, can include and exclude. The impact of illness contextual to wanting family involved can also lead to exclusion at a time when family involvement would be helpful. These factors are situated in the larger 'systems' of how *consultation* is viewed and interpreted from the perspectives of the *patient*, the family and whānau, clinicians, hospital management, and policy makers. The complexity involved in *consultation* practices piqued my curiosity, leading to this inquiry.

Not long after moving to Aotearoa New Zealand, I started post-graduate study which included looking at different forms of qualitative research design, including poststructural. I was particularly drawn to the works of Michel Foucault, as I felt his style of questioning practices and 'bigger picture' overview through discourse analysis supported a better understanding of how society can be constructed to meet the needs of particular individuals and groups. The notion of the interplay between discourses and the impact on people resonated with my interests in occupational justice, my background in humanitarian work, and work as a DAO.

The appeal of further education continued, and I completed a Master's in health focusing on the emergence of *recovery* philosophy in mental health service provision, using the works of Foucault as the methodological base. After completion, I realised that I had neglected to consider family and whānau within my research. This revelation (which seemed an injustice in itself), and the support and encouragement of my wife, spurred me into consideration of further study. Initially, family involvement in mental health service provision was narrowed down to the topic of family and whānau *consultation* as Section 7A of the MHA, 1992, pulling the threads of my background, values, and work life together. A Foucauldian discourse analysis seemed the perfect choice, as I had only started to gain an understanding on this poststructural take of analysis in my Master's degree. I believed that a poststructural position would provide a deeper level analysis of family and whānau *consultation* and enable me to see the 'bigger picture'. My intention with this thesis was to analyse the knowledge underpinning current practices and possibilities; to make visible underlying assumptions that limited and constrained, and through that make visible the possibilities for alternative practices.

Positioning Family and Whānau Involvement in Mental Health Service Provision

In order to position family involvement in mental health service provision and *consultation* as a process within compulsory assessment and treatment, it is helpful to provide a brief overview on the historical conditions that led to the separation and exclusion of persons considered mentally ill, and their return to society. This outline serves in setting the scene for my research through the shift from institutional to community-based care practices. In reality, in Aotearoa New Zealand, *community care* practices have been dominant for less than 40 years at the time of writing. I begin this section with a short introduction on the practices on persons perceived as mad or mentally ill in Europe to situate service provision in Aotearoa New Zealand as dominated by Western thinking and practices.

In 'Madness: The invention of an idea' Foucault (2011) noted texts and images from the European Middle ages and the Renaissance of practices rejecting those with 'deranged minds'. Placement in houses of detention within cities or extradition by boats to wander the waterways and countryside in the allegory of 'ship of fools' was suggested as commonplace (Foucault, 1989). Practices of detention, and the wandering and banishment of those perceived as mad, signified exclusion from society without examination. Mental illness, as a term, emerged during a period known as the 'Enlightenment' in 18th and 19th century Europe, when science surpassed religion and myth to explain the world, and where empirical knowledge was used to explain people's relationship with the world (Cooper & Burrell, 1988; Foucault, 1984e). These notions supported practices of 'scientific' examination, providing conditions for the study of madness (Foucault, 1989). The 'autonomous' subject, perceived as free from the control of God (Foucault, 1984e) was constructed from the values of reason and rationality, and defined by practices of productivity, such as work that enhanced democratic society (Burkitt, 2002; Miller & Rose, 1995). Thus emerged the notion of mental illness, constructed at that time as a lack of reason and rational thinking, of unproductivity, and of loss and error within the body/mind (Esquirol, 1845; Pinel, 1806).

Removal of those perceived mentally ill into places of observation, the asylum, and later, psychiatric hospitals, enabled examination, measurement, comparison, and categorisation to support and justify treatments to restore reasoning and rationality (Cooper & Burrell, 1988). The emergence of diagnostics, from classification and categorisation, in relations with neuropathy, psychology, and empiricism supported the legitimation of psychiatry as medical practice by the 20th century (Engstrom & Weber, 2005; Jablensky, 2007). Diagnoses, developed as classification systems by the American Psychiatric Association, surfaced within the 'Diagnostic and Statistical Manuals' (DSMs) and was legitimised through research (Moncrieff, 2010). In Western societies, psychiatric knowledge has dominated practices underpinning mental health service provision for over 200 years, with the different versions of the DSM from the 1950s framing the categorisation of mental and personality disorders.

Incarceration in the asylums and large psychiatric hospitals was the norm from the 19th century up until the end of the 20th century in Western societies. The banishment and detention of the mad prior to the 'Enlightenment', and the later placement, often long term, of persons deemed mentally ill into the asylums and large psychiatric hospitals, functioned as exclusion from society, community, and family. In New Zealand, for European settlers, the Lunatics Ordinance of 1846 provided the initial legal possibility to confine persons judged a danger due to mental illness. Consecutive Acts continued practices of incarceration based on assessment with limited acknowledgement of family[2] within processes. The practices of incarceration up until deinstitutionalisation signified a lack of family involvement in the decision making concerning the care of the person receiving treatment.

---

[2] Family, as a term, generally appeared in Sections contextual to making applications, responsible for payments (in Acts prior to the Social Security Act, 1938), and visiting rights. In the Lunatics Ordinance of 1846, family could request to take responsibility of the safe management of their relative to a judge.

My research begins with an analysis of the 1950s to the end of the 1970s when practices of institutionalisation were critiqued from within the profession of psychiatry, enabling the conditions for treatment in community settings. The shift away from long term incarceration provided new possibilities for family involvement, as practices reallocated into spaces within the community. Family and whānau are thus positioned in my research contextual to shifts in thinking and practices from the 1950s up until the time of writing, following a history of exclusion and confinement.

Situating the Study Within a Poststructural Gaze

My research provides an analysis of the historical and cultural conditions that led to the possibility and practice of *consultation* in its present form (at the time of writing). A poststructural methodology (discussed in detail in the next chapter) was taken to explore family and whānau *consultation* as a discursive practice, creating shifting and contested possibilities and constraints for family and whānau involvement in practices over time. A poststructural methodology makes visible the conditions and structures that normalise or encourage some practices and restrict others (Mease, 2017); thus challenging underlying assumptions and offering new possibilities for practice (Graham, 2005a; Tamboukou, 1999).

My research is concerned with identifying the historical, cultural, social, and political discourses that enabled the emergence of *consultation* as Section 7A in the MHA, 1992, between family and clinician, and, subsequently, its influence on contemporary practice. From a poststructural gaze, my research is founded on principles and values underpinning poststructuralism as a theoretical stance. Foremost, language (texts), has various meanings across time and contextual to differences within and between cultures. Therefore, without stable meanings, there can be no singular truth (Agger, 1991; Foucault, 1972). For example, psychiatry is one way of looking at what can be described of as ‘madness’ or ‘mental illness’, and the knowledge constructed by psychiatry has changed over time. Hearing voices and seeing things others are unable to hear could be understood as madness or in other ways such as possession by spirits or prophesy (Foucault, 2011). Other cultural groupings can provide other meanings that may or may not have relations with psychiatric knowledge; therefore, from this premise, there can be no single truth, or way of looking at madness or mental illness, or other descriptions used to describe how people behave differently from expected norms. From this standpoint, it is important to acknowledge that my own analysis of texts is not ‘truth’. Other researchers’ analysis of the same texts using the same or similar methods of analysis may identify different, equally valid inferences (Hook, 2001). The purpose of analysis is to provide opportunities to think about what knowledge can produce as practices; what knowledge can do. Rather than attempting to identify knowledge meaning, texts are analysed in my thesis to identify functions; how texts construct and shape practices, and not to identify ‘hidden’ meanings.

From a poststructural stance, different knowledge systems concerning specific subject matter, such as madness, compete with each other, culminating in the way things are done; in this example, how mental health services are provided. Psychiatry as a knowledge has dominated practices in Western societies and reached into non-Western societies through colonisation and other means, often limiting other knowledge systems, as identified in this study. This research thesis is, therefore, also concerned with the interplay between knowledge and power; how certain knowledge dominates other knowledge and materialises as a function within a practice to suit the needs of certain groups. Of interest in this thesis is how power enables the circulation of knowledge, such as from groups of people to other groups of people, and how power constructs and shapes people into particular positions, such as family has been constructed as *caregivers*. Four forms of power are referred to in my research (see Chapter Two for definitions) that support the production and circulation of knowledge. Although Foucault developed his ideas of power in various works, my use of sovereign power and disciplinary power were drawn heavily from his book ‘Discipline and Punish: The Birth of the Prison’ (Foucault, 1977); biopower from his book ‘The History of Sexuality: Volume 1’ (Foucault, 1978); and pastoral power from a shorter writing ‘The Subject and Power’ (Foucault, 1994h).

With a focus on how knowledge materialises as practices, an important consideration in reading this thesis concerns how knowledge and practices impact those involved. *Consultation* is a practice between family and whānau of the person under assessment, and a clinician who is responsible for overseeing certain legal processes with the MHA, 1992. Decisions made from *consultation* (or not, if it does not occur), ultimately impact the person undergoing assessment, family and whānau, and clinicians. This thesis is concerned with how *consultation* emerged, with a focus on family and whānau. By looking at historical periods to identify discourses that may have shaped the emergence of *consultation*, the first chapter of data analysis provides a broader gaze on family involvement in mental health service provision, and the conditions enabling involvement and *consultation*. The second chapter of analysis details shifts in thinking and practices for family and whānau and the conditions enabling the emergence of Section 7A *consultation*. The final chapter of data analysis explores how historical discourses continue to influence contemporary decisions concerning family and whānau involvement and *consultation*, even when presented as 'new' ideas.

At times, certain text is italicised to represent a *thing* that has been constructed. Although arguably, from a social constructionist perspective, all things have been constructed, the use of italics represents a knowledge or a function pertinent to this thesis. *Consultation* is one example, italicised as it signals a specific function as Section 7A of the MHA, 1992, but also constructed to provide relationships of communication between clinician and family in earlier iterations. At other times I use scare quotes to indicate a 'notion' but where meaning is erroneous or interpretative through association. An example of this is in describing a population as somehow 'flawed' through comparable statistics. A combination of both, such as '*risky*' signifies the construction of a term I want to signal as contestable.

Research on Family and Whānau *Consultation*

There has been no research on family and whānau *consultation* under Section 7A of the MHA, 1992 in Aotearoa New Zealand using a poststructural methodology. Although there have been several guidance documents and inquiries that included reviews of *consultation* (see Ministry of Health, 2006, 2012a; Paterson et al., 2018), these have used people's stories to compile themes and subsequently used to highlight or address gaps or issues in guiding documents and policy. My research has aimed to provide a broader, in-depth understanding of what keeps family and whānau involvement, including through *consultation*, an important practice.

Research into family and whānau involvement in Aotearoa New Zealand practices is limited. Studies concerning community treatment orders (CTOs)[3] (see Gibbs et al., 2004; Gibbs et al., 2006; Mullen et al., 2006) were amongst the first in Aotearoa New Zealand which explored family and whānau experiences of the MHA, 1992. More contemporary research has looked at whānau involvement in issues, such as advanced

---

[3] CTOs are where a court orders mental health treatment for up to 6 months which is then reviewed. These orders can become indefinite. Persons under a CTO are ordered by the court to attend appointments with a health professional and take medications as stipulated.

directives[4] (Thom et al., 2019); the second health professional in courts[5] (Muir et al., 2023); and from a rights based approach (Wharehoka, 2021). International research on family involvement in mental health legislation has tackled issues contextual to the nature of the countries' legislation. Research can be broadly categorised into the promotion of family involvement in mental health legislation (see Fiorillo et al., 2011; Førde et al., 2016) and the complexities arising from involvement (see Hallam, 2007; Norvoll et al., 2018; Wyder et al., 2018). My research aims to fill a significant gap in Aotearoa New Zealand research through exploring family and whānau *consultation* within the MHA, 1992, at a time when the MHA, 1992 has been criticised as outdated. (Paterson et al., 2018).

Writing Ethically: A Tangata Tiriti Perspective

The data accessed for analysis in this thesis are publicly available; therefore, no ethics approval was sought. However, my research considers ethics and draws from 'Te Ara Tika, Guidelines for Māori research ethics: A framework for researchers and ethics committee members', originally published in 2010 by the Health Research Council on behalf of the Pūtaiora Writing group. As noted above in the section on my background, I was born in England and moved to Aotearoa New Zealand in 2009. In my work and my research, I have commenced a relationship with Te Tiriti o Waitangi, the founding document of the State of Aotearoa New Zealand, from my perspective as tangata Tiriti (people of the treaty)[6].

Te Tiriti was negotiated between Māori hapū and the British Crown in 1840, in Māori text alongside an English version which has created contention between Māori and the Crown due to multiple differences between the two versions. Dominance of the English version of the treaty in politics and public life has enabled the domination of Western practices leading to ongoing marginalisation of Māori values and cultural practices, witnessed; for example, through health statistics (Came et al., 2020). Significant

---

[4] Advanced directives are developed by a person when well, stating future supports or treatments when unwell, such as preferred medications and the involvement of specific persons in care, such as family.

[5] The second health professional is involved in a judicial appeal (Section 16 of the MHA, 1992), by the person under the Act. The role of the second health professional is to provide a second opinion, from that of the treating doctor, to the presiding judge.

[6] For me, this term implies that by making my home Aotearoa New Zealand, I have a responsibility to support tino rangatiratanga (self-determination/sovereignty) as protected in te Tiriti o Waitangi. In my personal and work lives, and in the context of my research, I aim to develop an understanding of the history of this nation pre- and post-colonialism, and aim to build a relationship with Māori that supports their sovereignty.

disparities and *inequities* in health between Māori and non-Māori have evolved from several cultural barriers, including the loss of identity (Elers, 2014). The depletion of Māori identity is significantly complex and not for discussion in this introduction; rather, is discussed within Chapters Seven and Eight. However, it is important to note within this introduction that disproportionate rates of compulsory assessment, hospitalisation, and seclusion (Ministry of Health, 2023) demonstrate significant *inequity* in health outcomes, signifying a need for their inclusion in my research.

It is also important to note the potential for a loss of identity in research when non-Māori analyse and write about Māori. As a researcher identifying as tangata Tiriti, I am acutely aware of the dangers of representing Māori in ways that impact Māori rights, as presented in Te Tiriti o Waitangi, and the possibility of regurgitating colonial thinking that acts to further marginalise Māori (Cox et al., 2024). From my position of a European using European theory and philosophy when analysing texts concerning Māori, I acknowledge that I have been influenced by dominant Western knowledge that has shaped my thinking and methods of analysis. From this position there is a risk of unintended bias in my analysis through deficits in my understanding. From the perspective of tangata Tiriti, I have aimed to write in a culturally sensitive manner that advances social justice for Māori through upholding mana (respect) to Māori and Te Ao Māori (worldview). To support my aim, I have consulted with tangata whenua (people of the land) for feedback on my writing and considered and incorporated their views to the best of my ability.

In my research looking at family and whānau *consultation*, I have used data that refer to and were written by Māori. Some text dating back to the 1950s is clearly racist and offensive from a contemporary (as well as historical) perspective. My use of this text is not to re-circulate harmful text; rather, provide examples of how current thinking and practices can be harmful to Māori contextual to the influence of historical socio-cultural knowledge.

I have used te reo Māori (Māori language) at times followed by an English translation. Sometimes Māori phrases (in te reo Māori) have been constructed from Western perspectives to suit Western aims. Māori phrases may have more than one meaning; for example, the word whānau has several denotations and connotations, ranging from birth to different types of relationships between people for different purposes (Walker, 2011). I have, therefore, provided the translation contextual to the text's subject matter or focus of analysis when needed. As an example, I have provided different emphasis, at times, for a specific phrase: Te Ao Māori (Māori worldview) and Te Ao Māori (Māori cultural practices). I use the words Aotearoa (land of the long white cloud) and New Zealand together and interchangeably throughout the thesis, recognising both names for this nation.

Thesis Structure

The following section provides a brief overview of the main content for each chapter.

Chapter Two: Philosophical Position and Theoretical Frames of Reference

In Chapter Two, I define the philosophical underpinnings and theoretical parameters that inform the methodology of the research (discussed in Chapter Three). Poststructuralism is introduced, including how a poststructural stance was used by Foucault in works that are pertinent to this thesis. The notions of discourse and statements are presented, signifying the construction and function of knowledge from within this stance. I then introduce the four forms of power applicable to this thesis—sovereign, disciplinary, biopower, and pastoral—and the notion of resistance to power forms. Finally, I briefly consider the political conditions relevant to my analysis; liberalism, social welfarism, and neoliberalism.

Chapter Three: Foucault's Methodological Tools and Their Relevance to the Inquiry

In Chapter Three, I provide the limits of the methodology defined from the application of the philosophical underpinnings and theoretical parameters. Archaeology and genealogy are presented as methodological 'attitudes' that supported the construction of the inquiry focus and questions that guided the research. The conditions and rules of discourse analysis are introduced to situate my research from a Foucauldian discourse analysis stance.

Chapter Four: The Design of the Study

In Chapter Four I explicate how the theory and methodological tools supported the design of the study. Principles of discourse analysis discussed in Chapters Two and Three, are developed to clarify the methods of choosing, collecting, and analysing text to answer the research questions and maintain the focus of the inquiry.

Chapter Five: Community Care and the Problematic Family

In the first chapter of analysis, texts from the 1950s to the 1970s are used to explore the emerging strategies of identifying mental illness within the community and the conditions that enabled family and whānau involvement. I show how *community care* is problematised to reveal constructions of family that enabled their inclusion in practices. This chapter also explores the discursive construction of the psychiatric hospital within the strategies of normalising *community care* practices and mental illness as belonging in the community. The chapter concludes by exploring the taken-for-granted norm of Western family structures and practices.

Chapter Six: Familial Responsibility and the Construction of Partnership

In the second chapter of analysis, texts from 1985 to 2000 are used to explore the problematisation of *community care* practices and the emergence of family agency regarding practices of care and communication. The problem of rights and responsibilities concerning family are analysed as conditions for emerging iterations of *consultation*. Resistance to Western thinking and practices is investigated through the acknowledgement of Te Ao Māori (worldview) by the State and integrated into standards of care including family inclusion through notions of partnership by the turn of the century.

Chapter Seven: Constructions of Family and Whānau in the 21st Century

In the third and final chapter of analysis, texts from 2017 to the time of writing are used to explore contemporary notions of mental health service provision and *consultation*. I explore the notion of *risks* as dominant discursive constructs underpinning compulsory assessment and treatment practices, and then explore possibilities for resistance to the dominance of *risks*. *Recovery*, *equity*, and *wellbeing* are analysed as challenges to the dominance of psychiatric discourse and individualistic Western ways of thinking and doing. I conclude the chapter through exploring the construction of *consultation* within forms of cultural identity.

Chapter Eight: Discussion

The final chapter of the thesis extends my analysis presented in the previous three chapters through integrating the theory underpinning my analysis, the works of other authors, and the arguments arising from my own analysis. In this chapter I present two main arguments pertaining to my analysis with the aim to instigate discussion on the possibilities of future consultation practices.

Chapter Two: Philosophical Position and Theoretical Frames of Reference

The philosophical underpinnings and theoretical parameters discussed in this chapter inform the application of methodological considerations and study design of the research. Poststructural discourse analysis, using notions developed by Michel Foucault, analyses the functional implications of discourse concerning family and whānau *consultation* within the MHA, 1992. This chapter introduces the philosophical position of the research and the Foucauldian notions of knowledge, power, and the interpellation of subject positions, with a justification as to their relevance and application.

Poststructuralism

In this thesis, an overarching poststructural position was taken to analyse how knowledge associated with family and whānau *consultation* under Section 7A of the MHA, 1992 is constructed, distributed, and normalised as truth, thus shaping contemporary practices (Krug & Hepworth, 1997). Poststructuralism, an epistemological stance, emerged in the 1960s as philosophical critique on fixed understandings of phenomena and reality, and totalising explanations (Holmes & Gagnon, 2018; Krug & Hepworth, 1997; O'Farrell, 2005). To provide one definition of poststructuralism is difficult as it developed through the critical reflections of several French thinkers (eminently, Foucault, Derrida, and Barthes) and from a variety of disciplinary boundaries (Holmes & Gagnon, 2018). As a term, ‘post’-structuralism does not signify complete resistance or opposition to structuralism; rather, arose from critique on its deterministic and reductionistic aspects of a structural philosophical approach (Caplan, 1989).

‘Post’-Structuralism

Structuralism is the notion that sets of cultural phenomena are formed through hidden structures arising from thought/unconscious thinking and made visible through interrelationships with other phenomena. Understanding is gained through analysing broader systems that are fairly constant (Turner, 2014). Health, for example, might be understood through the relationships found across a variety of domains—in the media, workplaces, and literature. Health can be understood through how it is defined, and also through binaries as to what it is not, such as illness (Foucault, 1989).

A structural research approach is concerned with analysing and interpreting underlying structures within culture, knowledge, and language, developing insights into the broader relationships of products and culture (O'Farrell, 2005). A poststructural approach, goes further, by critiquing the assumptions and functions (Graham, 2005b) of texts (i.e., language, images, architecture), and the conflicts arising from differing contexts of meaning, which may be concealed within societal structures. Texts, such as the written word, have various meanings across different cultures; thereby as communication, may or may not achieve its intended goal. The concept of the death of the author (Barthes, 2001) signifies that as meaning is constructed by the reader, the author's meaning is lost. With meaning derived from the significance attached to certain words, language cannot be assumed to have stable meanings contextual to social practices (Agger, 1991). Without stability in meanings, there can be no totalising explanations (meta-narratives) for phenomena, thereby, no unifying systems of knowledge that represent a coherent developmental evolution of specific practices, as theorised within structuralism (Foucault, 1972). Family, as an example, has varied meanings within different cultural groups and across time. It can signify biological and non-biological relations between individuals and groups, it can represent relations in policy and law, and the social identity of cultural groups. Therefore, family, as a word and term, represents varied realities of meaning that have developed distinct to other forms in connected and unconnected ways.

As a research methodology, poststructuralism has been used extensively to examine what knowledge does (rather than means) as made visible within a wide range of social and cultural practices. It can be used to challenge how current practices are done and offer new possibilities for doing across disciplines (Graham, 2005a; Holmes & Gagnon, 2018; Krug & Hepworth, 1997; Tamboukou, 1999). It challenges through interrogating the structures normalised within practices (Mease, 2017), noting how knowledge is contingent on subjective interpretation and context (Graham, 2011). As a form of critiquing social practices, the stance enables "seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based" (Foucault, 1994g, p. 456). It does not, as Foucault (1994c) noted, assume that current practices are either good or bad; rather, identifies and questions what is taken for granted.

Modernism and ‘Post’-modernism

The notions of structuralism and poststructuralism are noted by Posner (2011) as rooted in modernism and postmodernism. Modernism grew from the European 18th century scientific and philosophical movements known as the ‘Enlightenment’. Explanations for how the modern world worked was grounded in the concepts of logic, reason, rationality, and teleology, with humans as progressive (Cooper & Burrell, 1988). A modern worldview encompassed a shift towards the concept of individualism through distinction from man as an extension of God (Norris, 1994). ‘Enlightenment’ and modernity thus defined humankind as autonomous (Foucault, 1984e), and promoted productive roles that aimed to enhance society through large scale technology, the production of wealth, and the development of scientific fields, such as medicine (Horkheimer & Adorno, 2002).

Postmodernism as a term was originally published in the 1930s, though popularised in the 1960s as “an effort to understand our historical presence, to perceive the interaction of language, knowledge, and power in our epoch” (Hassan, 1985, p. 119). Emergence of postmodernism and poststructuralism together, has the potential for interchangeable use, due to commonalities; for example, both are skeptical of totalising explanations and critical of how meta-narratives are used to shape worldviews (Stephanson & Jameson, 1989). In this thesis, postmodernism is viewed as a broader movement for critiquing modern understandings of the world through analysing shifts in socio-cultural and political representations of reality. Poststructuralism, chosen for this thesis, intimates a critique on the assumptions arising from structural knowledge through text analysis to question contemporary practices.

Poststructuralism and Foucault

“Do not ask me who I am and do not ask me to remain the same” (Foucault, 1972, p. 19). This statement captures Foucault’s dislike of labelling and positioning of himself and his works. Described as an academic, historian, gay icon, philosopher, anarchist, and social activist, Foucault’s life and research overlapped typical boundaries (O'Farrell, 2005). From a poststructural stance, his oeuvre of written works and interviews are contingent on a period of rapid societal change in post-World War II France. Foucault continually reconsidered and modified his ideas through retrospective reflection, scaffolding ideas from one analytical research topic to the next, enabling a development of ideas (Foucault, 1994c; Scott, 2009). He is typically associated with the movements of structuralism, postmodernity, and poststructuralism.

Methodological notions and principles developed by Foucault emerged during his analytical works (Fadyl et al., 2013a). As with his dislike for fixed and absolute explanations, he was indisposed to provide prescriptive methods for self and others (Graham, 2011). However, Foucault (1994c) differentiated some works, such as 'Madness and Civilization' (Foucault, 1989) as exploratory; whilst others, such as 'The Archaeology of Knowledge' (Foucault, 1972) as more method focused. His works signified an organic nature when writing "not only do I do not know what I'll be thinking at the end, but it is not very clear to me what method I will employ" (Foucault, 1994c, p. 240). Foucault developed his own theories using or forgoing ideas from philosophers, such as Nietzsche and Marx, often transforming them into tools to meet the requirements of his own inquiries (Garland, 2014). Consequently, the notion of researchers using a Foucauldian toolbox approach to choose methodological notions that fit with their own areas of analysis seems a natural response to 'using' Foucault.

The methodology for this thesis emerged during its formation. An organic approach developed through reading Foucault, whilst thinking broadly about *consultation* highlighted notions and principles used by Foucault in his analysis that appeared to 'fit' with the topic of this research. The thinking and writings of Foucault (e.g., 1971, 1972, 1977, 1978) shaped this thesis through refuting notions of progressive development, denying universal meanings, and teleology within mental health service practices. Instead, social practices, such as *consultation*, are viewed in this thesis as transitory in nature (Olssen, 2004), shifting and changing according to time and context. Family and whānau involvement in compulsory assessment and treatment in the early 2020s is seen as contingent on the meanings arising from language and practices of a present time shaped by the past. Therefore, an exploration and analysis of past practices concerning family and whānau involvement in mental health service provision provides possible explanations as to how present practices of *consultation* under legal proceedings occur in their present forms. Notions and principles developed by Foucault and others that have used his works underpin this methodology to enable historical analysis of contemporary practices. To support the process of analysing a history of present practices, Foucault's position on discourse analysis was chosen to identify relations between practices and knowledge.

Discourse

Discourse is concerned with language, knowledge, and practices. In its simplest form, such as a dictionary definition, discourse is noted by words such as “communication”, “speech”, and “writing”. Analysis of discourse, again in dictionary terms, notes a study or exploration of rules informing language and communication (Dictionary.com, 2023). Providing fixed meanings of discourse and discourse analysis is complex as definitions constitute and delineate knowledge from within different epistemological and ontological orientations (Bacchi, 2000). Discourse can be analysed from different positions, as per the following examples. Language-based analysists identify contexts from unit analysis of the written and spoken word to reflect on assumptions concerning communication (cf. Schiffrin, 1997). Social theory-based analysis questions how discourses represent realities, the world, and the productive activities that people engage in to comment on social practices (cf. Fairclough, 2000). Policy-as-discourse analysts critically reflect on how policy constitutes problems within society, offering insights into political influences shaping modes of rule (cf. Bacchi, 2000). These three examples (language-based, social, and political forms of analysis) highlight some possibilities discourse analysts may take, which makes the provision of an overarching definition complex.

I have chosen to use a Foucauldian stance that falls within the remit of socio-political analysis to analyse the constitutive and functional nature of discourse, with specific attention to the relations between policy, law, and social practices. Problematisation of *consultation,* as a process, was used to challenge conventional understandings and assumptions attached to the word/practice, such as noting how political structures and morality shape meanings of *consultation* (Foucault, 1994e). The writings of Foucault and those that develop notions from his writings for research assisted me to craft the following definition of discourse.

Foucauldian Discourse

Foucault (1972) noted that “discourse can be defined as the group of statements that belong to a single system of formation; thus I shall be able to speak of clinical discourse, economic discourse, the discourse of natural history, psychiatric discourse” (p. 121). From a Foucauldian perspective, discourse represents the production of communication through different forms, such as written and spoken language, which indicates meaning and knowledge through its relations. Communication of knowledge concerning mental illness by clinicians working within a medical approach to treatment might be grouped as psychiatric discourse. The integration of other disciplines, focusing on treating illness from varied health perspectives might be grouped together as clinical discourse. Artefacts, too, can provide meaning, signposting knowledge that underpins their formation. For example, the space of a building dedicated to addressing illness signifies the *hospital*; the language used by those in the space, such as discussion on disease and treatments, further signposts its meaning along with equipment used, such as an electroencephalogram (EEG) machine. Relations between spaces, and the language and objects used in the space forms, through arrangement, a system of knowledge. The focus of this research is on what discourse produces as practices; that is, how communication, in written and spoken form, objects, and spaces construct practices. Specifically, in this thesis, the focus is on how discourses construct practices enabling family and whānau involvement and *consultation* in mental health service provision.

In this thesis, discourse functions through constructing and shaping thinking and practices. Foucault's notion of discourse outlined in his inaugural lecture at the Collège de France 'Orders of Discourse' (1971) highlights how practices are shaped through internal and external rules, systems, and procedures. Certain discourses are expressed and disappear, other discourses remain, appear in hierarchical systems, and are given new opportunities to reappear through commentary, interpretation, and classification. Internal rules, such as the influence ascribed to specific authors; for example, psychiatry, is reinforced through institutional systems, such as biomedicine, which organises and classifies discourses (Armstrong, 2015). Discourses circulate through policy, law, pedagogy, research, and the media, for examples, enabling commentary which sanctions and normalises discourse, and thereby authorising certain discourses dominance over other discourses' (Bacchi, 2000; Foucault, 1971).

The division of madness and rationality, and the 'will to truth' are specifically relevant as external rules of exclusion for exploration in this thesis. The division of madness and rationality, embedded within the knowledge and structure of mental health service provision, enables practices that aim to seek out the 'truths' associated with madness for intervention, making family involvement possible, but also constraining their involvement. The promotion of 'truths' occurs through repetition and recirculation of discourse, from positions or groups providing legitimacy through expertise (Graham, 2005; Hook, 2001), whether clinical or lived experiences. The DSM defines mental disorders as legitimised by the author of psychiatry; enacted within the disciplines of clinical health sciences; and promoted as ‘truth’. Its acceptability in contemporary Western mental health service provision denotes a hierarchical position above other interpretations or explanations of madness, such as non-Western and other cultural understandings (Foucault, 1971, 2011). Analysis of external and internal rules of exclusion can identify how rules, systems, and procedures enable hierarchical dominance between discourses (Hook, 2001). A starting point of discourse analysis is the identification of statements, as suggested by Foucault (1972) in his book the ‘Archaeology of Knowledge’.

Statements

Foucault (1972) noted how discourses are comprised of statements found in text: microelements that act to signpost knowledge assumptions. Signposting arises from regularities and rules within and between statements enabling possible meanings inside (but not limited to) language, and practices. Statements are, therefore, contextual and referential (Armstrong, 2015; Graham, 2005a), co-existing with innumerable other statements, incompatible and harmonious. For example, mental health definitions from two different websites—World Health Organization (WHO) and the Evangelical Alliance—construct mental health from within two outwardly different contexts; however, include harmonious statements through noting the positive role of productivity on wellbeing. The WHO (2023) has defined mental health as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community” (para. 1).

Newham (2022) wrote that the

> Hebrew word “shalom” is the closest concept to our idea of mental health, but it’s greater and more beautiful. In Genesis 2, we see shalom in its fullness; there is companionship between Adam and Eve, connection to God, purposeful work and security in the garden of Eden – and these things reflect the elements of good mental health. (para. 2)

Discourse analysis in this thesis involves identifying and analysing the relations between statements and the rules that shape their use. In the above examples, underlying rules include the ability to function and produce things through internal means of coping in the first text and externally through connection to God in the second text. Identifying the underlying rules of discourse can then support identification of their function as practices (Foucault, 1972). Using the above examples, the WHO (2023) provides a global definition that aims to shape international and national policies concerning service provision that includes a function to increase coping mechanisms to overcome stress, whereas Newham (2022) provides a biblical translation of mental health to support an understanding of mental health for members within the church that correlates with the values of the church. As Graham (2011) succinctly noted: “one looks to statements not so much for what they say but what they do; that is, one questions what the constitutive or political effects of saying this instead of that might be?” (p. 5). In this thesis, an example might be how statements that depict family and whānau as *partners* in policy may increase their inclusion within specific mental health service processes and other functions.

Foucault (1972) used the term discursive formations to describe the regularity of relations between statements that form discourse and the objects of which they speak and the conditions that make formation possible. The processes of (re)production, (re)formation, and constraint of individual discourses, however, intimately intertwine and compete (Hook, 2001). Competition between discourse underscores the dynamic nature of knowledge in constant flux within practices, “a relation of struggle, domination, servitude, settlement” (Foucault, 1994j, p. 9); the power/knowledge relationship within and between multiple discourses. In this thesis, the notion of ‘expertise’ can be constructed from the lived experience of caring for a family member with a mental illness, and through theoretical and practical learning attached to a discipline, such as nursing. The discursive formation of expertise based on differing foundations may act to dominate or serve where they surface, such as in policy, thus enabling hierarchical value and positioning within practices.

Power/Knowledge

Foucault used the conjoined power/knowledge as a term signifying how power operates through accepted forms of knowledge, such as those arising from scientific discourses and the institutions that generate them: “Truth…is linked in a circular relation with systems of power that produce and sustain it, and to effects of power which it induces and which extend it – a ‘regime’ of truth” (Foucault, 1994k, p. 132). However, Foucault developed his notion of power as omnipresent in all social interactions, working through all levels of society from the individual up to the state (Feder, 2011; Lynch, 2011).

Power, according to Foucault, acting through social interactions aims to influence the conduct of individuals and groups; to generate subjects. He wrote power "makes individuals subjects. There are two meanings of the word 'subject': subject to someone else by control and dependence, and tied to his own identity by a conscience or self knowledge" (Foucault, 1994h, p. 331). Within the parameters of this thesis, subjects include the position of *patient*, constructed from the lived experience of mental illness, an identity formed through its function in mental health service provision and through its subsequent acceptance by the person experiencing services. *Patients* are also subject to the possibility of forced assessment and treatment through legal proceedings.

Power is not something that is possessed; rather, power is exercised on subjects to think and behave in expected ways, for themselves and others. *Patients*' functions include attendance of appointments, informing clinicians of symptoms, and taking medications, as examples. Power acts through the subject position of *patient* in relation to the rules defined within psychiatric discourse. Power is, therefore, a positive force, acting to construct desired subjectivities (Mayes, 2009) based on specific discourses in circulation. Four forms of power relations developed by Foucault are relevant for this thesis, contextual to the construction of subjectivities: sovereign power, disciplinary power, biopower, and pastoral power.

Sovereign Power

Foucault (1977) graphically presented sovereign power, in his book 'Discipline and Punish: The Birth of the Prison', through the execution of a condemned body in 1757 France, by the orders of the King. Noting the legislative and prohibitive nature of this power form (Lilja & Vinthagen, 2014), Foucault defined law in those times as an extension of the will of monarchy, an exercise of power in its most visible form. As a mechanism of discipline, the function of public execution demonstrated an operation of absolute power, using the body of the condemned to link crimes against society as crimes against the monarchy. This top-down approach to power, dominant until the 19th century, acted to repress and control individuals through fear and threats of violence. Power/knowledge emerged from the act of witnessing, inquiry and recollection of the absolute right of the King to take life or let live (Foucault, 1977, 1994j). Foucault postulated the demise of sovereign power through authorities' recognition of increasing public revolt and scorn of open executions. Displays of mocking, coincided with shifts in thinking arising during the 'Enlightenment' movement of the 18th century, that advocated reason, the sciences, liberty, tolerance, and a separation of religion and the state (Schmidt, 2006).

Sovereign power, noted by Foucault (1977) as being supplanted by disciplinary and biopower in dominance within contemporary times, remains, however, relevant for exploration within this thesis. As argued by Smith (2000) “law and the juridical field operate to manipulate and control expert knowledge to their own ends. In so doing, law continually exercises and re-affirms its power as part of the sovereign state” (p. 283). Sovereign forms of power emerge in this thesis through significations of coercive and controlling psychiatric practices surfacing through mental health law and enabling critique.[7] In this thesis, the function of sovereign power signifies the forced movement of people, such as forced hospitalisation, and acts of violence on the body, such as restraint, sanctioned through law. A less visible force of power that diminishes possibilities for critique and aims to manipulate and control subjects, emerges through the notion of disciplinary power.

Disciplinary Power

Foucault (1977) explicated the term ‘bodies’ as a precursor to the formation of individualism. Moving on from a visible sovereign power in his book ‘Discipline and Punish: The Birth of the Prison’, disciplinary power signified a less conspicuous though more meticulous means of controlling bodies to act in desired ways. Using examples from the army, factories, schools, and ultimately a focus on punishment and prisons, Foucault noted how controlling the actions of bodies enabled forms of utility and docility, their usefulness and compliance. Disciplinary power generates individual traits through the growth of desired skills and abilities, whilst reducing possibilities for resistance (Hoffman, 2011). As an example, educational practices may increase the skills of family and whānau as *partners* in mental health service provision. *Partnership* may entail involvement in treatment planning, based on psychiatric and clinical discourse. Family inclusion in treatment planning may be subject to acquiescence to the rules underpinning service provision that draw from psychiatric and clinical discourse. Resistance from family to the rules constructing *partnership* may provide the conditions for their exclusion.

---

[7] Examples in this thesis are from the antipsychiatry and service user movements explored in Chapters 5 and 7 respectively.

Foucault (1977) implied that disciplinary power was not a new ‘discovery’, rather it emerged through a variety of processes and locations to meet specific needs, such as a disparately skilled and compliant workforce in the growing number of factories during the Industrial revolution. The notion of disciplinary power, operating within mental health service provision to generate individual subjects to meet specific needs, has been explored from clinical (cf. Bradbury-Jones et al., 2008; St-Pierre & Holmes, 2008) and carer (cf. Heaton, 1999; Sadler et al., 2018) perspectives. This thesis explores the notion of disciplinary power generating specific individuals to meet specific needs within iterations of *consultation*, and the techniques and strategies employed to do so.

Foucault (1977) noted several techniques and strategies as enablers for disciplinary power to succeed. The ‘arts of distribution’, a technique to signify the partitioning of bodies within enclosed spaces, enables forms of observation and the promotion of desired conduct. Within a hospital setting, for example, the design of a ward with patient spaces, nurses offices, bed spaces, can hinder or support observation. Forms of surveillance assist hierarchical observation so that nurses observe patients, enabling the promotion of health literacy. But nurses too are observed by managers and patients to ensure they ‘act’ as nurses (St-Pierre & Holmes, 2008), as prescribed, for example, by ethics, standards of practice, and codes of rights.

Architecture as an enabler of disciplinary power to coerce behaviors through surveillance was explored by Foucault (1977) through Bentham’s conceptual design of the prison, the panoptic tower. Acting as a centre of observation for knowledge and training, a central tower and a periphery of lighted cells, permits “a state of conscious and permanent visibility” (Foucault, 1977, p. 201) of those observed, who know they may be watched at any time but cannot see the observer. Combined with the possibility of punishment for non-conformity, this technology works to compel those who are observable to exhibit desired behaviours at all times, as they do not know when they are being observed. Panoptic-inspired practices have infiltrated ‘new’ spaces within society, architecturally and beyond, from facial recognition in urban spaces (Gray, 2003) to digital communication systems (Manokha, 2018). This thesis takes an open approach to how panopticism transforms itself to meet new needs within the broader practices constructing *consultation*.

As noted above, disciplinary power has been formed in a variety of settings and locations to meet specific needs. As well as allocating bodies in spaces, controlling activities through strategies, such as timetabling when activities transpire, can affect productive output. Meticulous rules of activity engagement can manipulate bodies to perform in certain ways, increasing utility (Foucault, 1977). The combination of space, time, and the control of activity supports the development of systems that enable individuals to take on specific functions, such as within the practice of *consultation*; legitimised through, where, when, and how tasks involving training and examination, for example, take place (Foucault, 1977). Spaces and the control of activities involved in iterations of *consultation* in this thesis are explored to note how manipulating environments facilitate techniques and strategies for hierarchical observation and the promotion of desired conduct. The out-patients clinic discussed in Chapter Five is one example of a space examining relations between family and the primary person receiving services within a hierarchical gaze.

Disciplinary power judges utility and docility through standards placed on conduct. Measuring behaviour as normal or abnormal, graded in comparison with other behaviour, ranked or classified, enables possibilities for reward and punishment against norms (Hoffman, 2011). In Western mental health service provision, diagnoses are a palpable example of judging experiences and conduct against standards of normality defined through psychiatry (Moncrieff, 2010). Disciplinary techniques measure conduct by combining hierarchical observation and a normalising gaze through examination (Foucault, 1977), as in health systems where a clinical examination is employed. Foucault (1977) noted how examination “manifests the subjection of those who are perceived as objects and the objectification of those who are subjected” (pp. 184-185). In other words, subjects, individualised to act in certain ways, are objectified to see whether they are acting as they should be.

Psychiatry’s construction of a case, through observation and examination of functioning, enables case notes and other forms of documentation to fix the individual. Examination of their presentation, skills, ability, and compliance, as examples, present opportunities for judgement. Classed as ‘faulty’ objects provides possibilities for subjectification through external manipulation and control, but also internally through technologies of the self to meet norms. An example of this can be found in Chapter Five, where European anthropological discourse produced in research constructed Māori parenting skills as deviant, thus constraining and excluding Te Ao Māori (worldview) in practices.

Foucault (1994i) explored internal discursive construction to meet needs and attain a sense of meaning, purpose, and ‘self-care’ in life. Individuals “effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being" (Foucault, 1994i, p. 227). Established through a relationship with societal rules and values, concepts, such as healthy living, are incorporated as practices to meet normative expectations through internal construction of accepted subject positions. Foucault saw this focus on the self as a duty arising from Christianity's promotion of reflection on self-knowledge; an acknowledgement of internal desires, and faults, as examples, disclosed through confession. This thesis examines how external forces intersects with technologies of self to construct subjects to think and behave in certain ways, and the ways that this occurs, such as through confession.

Integral to the examination is the confession, a technique to extract knowledge from those under examination. In his book 'The History of Sexuality: Volume 1', Foucault (1978) described how the ritual of confession, originating in religious practices, developed a central role for producing 'truth':

> The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell. (p. 59)

Confession is central to the examination through the extraction of knowledge. It requires expression to another in the form of self-examination. Of interest in this research is how employment of confession constitutes those involved to take on subject positions from the recognition of self as a domain of possible knowledge (Foucault, 1994h). Chapter Six provides an example of tensions between external and internal constructions of family as *caregivers* and thus the possibility for familial expertise, arising from confessions in inquiries and submissions.

Discursive power, from a Foucauldian perspective, translates into the constitution of subjects, arising from disciplinary techniques, through external forms of control and domination and internal self-regulation and formation (Martin &Waring, 2018). Disciplinary power, within this thesis, assists identification of the techniques and strategies in object formation and how subjectification occurs through external loci of control and self-formation. Moving away from a focus on the body, Foucault (1978) shifted attention to the species body and the notion of biopower operating on populations. *Consultation* as a practice has transformed since its formal emergence in 1999 in the MHA, 1992, through techniques and strategies arising through administrative practices.

Biopower

In his book ‘The History of Sexuality, Volume 1’, Foucault (1978) noted an expansion of disciplinary power from a focus on the body (anatomo-political) to a focus on the “species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, with all the conditions that can cause these to vary” (p. 139). Regulating and managing aspects of life at the population level through administrative practices, such as through statistics, biopower organises through norms. Biopower enables the formation of hierarchy and qualification within practices through measurement. It incorporates law through promoting regulatory functions, not to inhibit, but to generate productive subjects within specified limitations.

Policy is an example of a strategy used to control and manage populations in preference to threats of ‘violence’ arising from law. It achieves this through identifying a target group (subjects), formulating a desired outcome (shaping), and using measures and interventions to reach targets (norms) (Taylor, 2011). The notion of *equity* as an administrative strategy, discussed in Chapter Seven, provides an illustration of the use of statistics in policy and guidelines to categorise Māori as a population experiencing health *inequity*, authorising specific practices and forms of governance under the category of health *equity*.

Biopower expanded the instrument of the norm through institutional and judicial apparatus, with a focus on the health and *wellbeing* of populations (Foucault, 1978, 1984c). The MHA, 1992, is an example of how law and administrative processes are used to regulate the practice of responding to ‘mental illness’ within the general population. Mental health services function through promoting behavioural norms and normalising specific treatments, such as taking medications or engaging in psychotherapy. Possibilities for a sovereign form of power of the State exist, however, through compulsion when required, highlighting fluidity within the complex relations of the notions of juridical forms of power and biopower, which is a concern taken up in this thesis.

Biopower, as a term, (along with biopolitics), was used by Foucault during the series of lectures in 1978 at the Collège de France that explicated the political regulatory mechanisms acting on populations. The term, governmentality (also appearing during these lectures) focused on the problematisation of governing populations. Foucault (1994b) noted the 'art of government' appearing in political treatises from 16th century Europe, aimed to manage the economy of the state in terms of wealth, resources, and goods at State and individual level. Maximising economy (meaning more than the contemporary association to finances) of the State through managing populations, enabled practices of surveillance and control. Governmentality addressed and questioned the

> correct way of managing individuals, goods, and wealth within the family (which a good father is expected to do in relation to his wife, children, and servants) and of making the family fortunes prosper – how to introduce this meticulous attention of the father toward his family into the management of the state. (Foucault, 1994b, p. 207)

In this sense, governmentality is concerned with the practices that shape the conduct of individuals and groups, from external sources such as health literacy, and internally through self-examination of engagement in practices. Occurring through interactions between government departments and communities (Fadyl et al., 2013a), governmentality is explored within this thesis, such as through the rupture from institutional care to practices of care in the community at a macro level; and through the mechanism of rehabilitation clinics in the 1970s (see Chapter Five) that enabled the examination and inclusion of family in interventions at a micro level.

Governmentality as a notion is also explored within this research as to the extent family acts as "the privileged instrument for the government of the population" (Foucault, 1994b, p. 216); in this example, within the boundaries of *consultation* practices, to circulate specific discourse, such as related to *caregiving*. The means to circulate specific discourses from the population level back down to individuals, in ways that are understood and enable adoption, is explored in the final form of power that has implications in this thesis: pastoral power.

Pastoral Power

Pastoral power, according to Foucault (1994h), has roots in Christianity through the biblical metaphor of the salvation-orientated shepherd overseeing the morality and conduct of individuals under their gaze. Four historical characteristics underpin the notion of pastoral power: delivering individuals to salvation; self-sacrifice for the sake of the flock; concern of individuals and populations; and gaining access to how people think. From the 18th century, the function of pastoral power shifted from a Christian focus on spiritual salvation in the next world, to ideas of *wellbeing*, health, and security in this world (Foucault, 1994h). These shifts occurred via institutions of the modern State; for example, health services, through voluntary organisations, and the family.

The notion of self-sacrifice differentiates pastoral servitude, using intimate relations to shape behaviours rather than threats (Mayes, 2009). Foucault (1994h) noted pastoral power as individualising (concerned with individuals) and totalising (concerned with populations). Individualisation occurs through sanctioned discourses (e.g., concerning health and education), enabling thinking and performance in ways promoted by the State. Subject positions, such as *carer*, are encouraged to care in specific ways and when certain practices are adopted by the many, they become normalised within specific populations.

Pastoral power, as a technology of governmentality (Martin & Waring, 2018), functions through the pastor's use and translation of discourse within practices to naturalise and embed desired values and conduct. It enables a relationship of self-disclosure (e.g., from the *patient*) and scrutiny (e.g., from the nurse) to identify behaviours requiring monitoring and shaping (Winch, 2006). However, inducing change at the level of the family and community also requires a 're-culturing' of those taking on pastoral roles (Jones, 2018). This thesis explores the dynamics of relationships between the family and the State to illuminate how "the connection between government discourses and the constitution of subjects is effected" (Martin and Waring, 2018, p. 1298). In Chapter Five, the extension of psychiatry into the community is explored through 'respected' professionals, such as the public health nurse, translating psychiatric discourse to identify the causes of mental illness and, consequently, shifting the gaze onto intimate relationships within family units.

Towards the end of his life, Foucault (1994h) elucidated that the subject, not power, was the general focus of analyses; how humans are transformed into subjects. As a methodological stance, this thesis takes up how power/knowledge constructs productive subjects to meet needs, how subjects are objectified through division, such as mad or rational, and how ways of being are incorporated through technologies of the self. However, this is all far from a one-way process, as practices enable a variety of responses arising from how meanings of language are culturally specific. Responses to dominant practices may be consenting or offer up resistance. Possible responses may include forms of resistance leading to change: “So many things can be changed, being as fragile as they are, tied more to contingencies than to necessities” (Foucault, 1994g, p. 458). Resistance is, therefore, an integral concept within Foucault’s notions of power considered within this thesis.

Resistance

Foucault’s notion of modern power forms, that is, those without threats of violence, operate through the internalisation and adoption of norms. Though power is omnipresent within all social interactions (Feder, 2011), resistance to power forms are conceivable by “thinking and being otherwise within them” (Oksala, 2011, p. 93). Foucault (1994f) noted that resistance is required for power relations to exist, and that possibilities for freedom may involve accepting the techniques and strategies of disciplinary power, but refusing end goals, hence the subject position imposed. Foucault (1994h) stated resistance to subjection

> is to attack not so much ‘such or such’ an institution of power, or group, or elite, or class but rather a technique, a form of power. This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. (p. 331)

Forms of subjection, contextual to *consultation* practices, are explored in this thesis to identify possibilities for resistance through alternative subject positions. Family and clinicians may be promoted to behave in specific ways to meet specific needs, with education and guidelines as strategies used to increase expertise. However, due to misunderstandings arising from language or through resistance to subjection, intended goals can vary widely in accomplishment. For example, family and whānau might resist the expected goal of *partners* of mental health services (Ministry of Health, 2006) through taking on a position of *advocate*, using the abilities gained through education for different means. Resistance thus functions through assenting to the techniques and strategies at work, but rejecting the goals and taking alternate subject positions through critical thinking (Thompson, 2003).

The approach taken in this thesis reflects critical thinking in a Foucauldian sense as a 'history of the present', posing a question on a contemporary problem and working out its genealogy (Garland, 2014) relative to Foucault's understanding of history as an underpinning philosophical concept. Resistance by Māori to monocultural Western-led service provision is introduced in Chapter Six and expanded on in Chapter Seven through the concepts of *equity* and *wellbeing*. However, although resistance enables possibilities for freedom, this thesis also explores how resistance can enable different iterations of governance, as investigated through 'Whānau Ora' in Chapter Seven.

Research Considerations

Foucault's genealogical analyses considered how dominant political and economic ideology entwined with productive forces of power at the level of populations. Noting how knowledge is contingent on context (Graham, 2011), and how discourses are reliant on conditions that support their existence (Foucault, 1971), liberalism, social welfarism, and neoliberalism are briefly introduced as conceptual considerations shaping practices concerning family and whānau involvement in mental health service provision, offering possibilities for the construction of *consultation*.

Liberalism.

Classic liberalism, as a theoretical framework, emerged in 18th century European intellect that challenged monarchial forms of social order through promotion of human individualism and rights. Limited State interventions acted to protect individual property whilst providing conditions that supported individual self-interests. Generating relations between democratic forms of government and market economies, liberal notions aimed to balance state interventions with laissez-faire economic management to enhance the health and wealth of populations (Cheyne et al., 2008).

At the turn of the 19th century, in Aotearoa New Zealand State interventions introduced by the political group, the 'Liberals', included property taxes, and welfare schemes, such as old age pensions. Welfare for the poor held negative connotations, through beliefs it reduced self-reliance and population productivity. Paid work was, instead, a central feature of welfare, through relations between social policy criteria and industrial bargaining and fixed wages, negotiated through employers and unions (Bray & Walsh, 1998; Humpage & Craig, 2008). Tensions between individual and community responsibility and the effects of welfare on character fueled early 19th century debates on notions of citizens' rights versus charity to meet needs. The notion of welfare distribution enabled categories for receiving benefits; age, ability, and gender, decided, in Aotearoa New Zealand by European white males. Ethnicity as a determinant of criteria, enabled opportunities for discriminatory practices based on race, such as reduced pension rates for Māori (Bryson, 1992; McClure, 1998).

Liberalism, seen through discursive practices, such as patient and family rights, is pertinent to this thesis through a focus on functions that represent specific interests. In Chapter Six the emergence of *patient's rights* made visible the lack of rights for family and their interests within the position of *caregiving*. Right based discourse had a significant impact on the emergence of *consultation* in 1999, generating the position of *principal care giver* and a form of family agency in legal processes. However, tensions between rights and expertise have continued to limit, constrain, and provide possibilities for iterations of *consultation* from a liberal perspective in relations with the notion of expertise, as explored in Chapter Six.

Expert rule, based on truth claims, such as psychiatric discourse, has acted to regulate and manage specific populations through qualification and hierarchy, thus governing conduct through state approval of professionals (Foucault, 1978; Rose, 1993). In this thesis, liberalism as a function is thereby noted as a condition enabling disciplinary mechanisms, and the construction of individual subjects based on hierarchical observations and a normalising gaze (Foucault, 1977). Examples of regulation are discussed in Chapter Six through how Māori were excluded from participating in clinical roles through Western qualification systems.

According to Rose (1993), liberal forms of governing were noted in the early 20th century as failing aspects of social, moral, and economic society. Increased regulation, and thereby increased political and State interference, aimed to address social issues in Europe, the United States of America (USA), and Aotearoa New Zealand through targeting inequality (Easton, 1980; Humpage & Craig, 2008). This was particularly visible following the financial Depression in the 1930s that highlighted inefficient systems of aid for the high levels of the unemployed (McClure, 1998). Social policy as a strategy for tackling inequality shifted to encompass a greater emphasis on State welfare.

Social Welfarism

With welfare signifying wellbeing, social welfare as a term can imply practices arising from policy focused on social issues ranging from health and education to town planning and the shaping of physical environments (Bryson, 1992). Social policy was described by Foucault (2008b) as government practices promoting equal access to consumer goods by acting as a counterweight to inequalities arising from unrestrained economic processes. Easton (1980) noted the aims of institutionalised service provision post-World War II in European and commonwealth states, including Aotearoa New Zealand, was to meet needs through addressing social inequalities arising from poverty.

Keynesian economics aimed to reform society through equitable distribution of wages, income security and the provision of universal services, such as national health schemes. The popularity of the State providing welfare in Aotearoa New Zealand was in part due to general unacceptability of unregulated distribution of wealth and services under private markets. Individual needs and development through collective measures aimed to reform society through administrative techniques (Bryson, 1992). The New Zealand Social Security Act, 1938, for example, aimed to address inequality and eliminate the stigma attached to poverty through ensuring basic needs of citizens would be met through government institutions (Easton, 1980). Payment for being in hospital was made by the State rather than the individual or family. Social welfarism continued to dominate social policy in Aotearoa New Zealand until the end of the 1970s (Humpage & Craig, 2008).

Exclusion from accessing basic needs enabled the production of vulnerable and thus marginalised populations related to age, health, employment status, and other factors denoting citizenship (Rose, 1999). Organising welfare as strategies for productive engagement of the marginalised in community life enabled new opportunities for categorisation and interventions, providing further relations between social and economic development (Foucault, 2008b; Rose, 1999). The expansion of expertise through disciplinary specialties addressed specific needs ranging from the rehabilitation of disabled people to training schemes for the unemployed (Rose, 1999). Systems, potentially lessened *burden of care* placed on families (Humpage & Craig, 2008) but, through a gaze on low income families, enabled associations between conditions such as poverty and family morality and conduct (Easton, 1980).

Family, within an ethos of social welfare, became a site for research to identify how poverty and lack of schooling linked with crime and youth delinquency rates (see Davies & Dax, 1974); or how parents generated the emergence of mental disorder in their children (see, Sleek, 1980). Māori were particularly problematised from the 1950s, with research constructing collectivism as deviant and linked with crime (see Chapter

Five). In this thesis, social welfare practices are seen as inextricably enabling strategies that aspire to improve the welfare of populations through opportunities to assess, monitor, and regulate conduct. Within this research, social welfare as practices is specifically visible in Chapter Five when disciplinary experts, such as the social worker, accessed family homes from the mid-1950s for the identification and reduction of factors linked with mental illness, enabling the removal of children into State run hostels and foster homes.

Neoliberalism

Significant criticism of Keynesian economics and social welfarism constructed as failings of State interventions to safeguard social wellbeing enabled a shift back to liberal thinking, albeit with greater emphasis on market rules (Larner, 2000; Rose, 1993). Neoliberalism signalled a swing to the political ‘Right’ in policy that prioritised the welfare of the economy over social goals. Vilification of state interventions occurred within an ethos that the market was best placed to provide economic and thereby social wellbeing as state interventions stifled individual choice and self-interest (Humpage & Craig, 2008). Think tanks, such as the Chicago School of economics and the Mont Pelerin Society, founded in the 1930s and 40s respectively, became increasingly influential from the late 1970s in the UK and USA (Davies, 2014). Neoliberal thinking arrived in Aotearoa New Zealand in the 1980s (Humpage & Craig, 2008).

Neoliberalism of the 1980s and 1990s broadly represented a political and intellectual movement that promoted the concept of the market as an effectual means to govern most aspects of life (Esposito & Perez, 2014). Rodgers (2018) noted that neoliberalism signalled an intellectual project linking human activity with the market, enabling commodification of the self as human capital within all spheres of life. Neoliberal practices constructed individuals “were *active* in making choices in order to further their own interests and those of their family: they were thus potentially active in their own government” (Rose, 1999, p. 142). Within an attitude of neoliberalism, active citizenship in market driven environments imply, through construction, *consumers* who can choose between services and thus be empowered by their choice (Lupton, 1997).

Neoliberalism is pertinent to this thesis as a market reality of social life has encouraged people to act in ways that meet market demands. Market values include individualism, self-reliance, and personal responsibility within a culture of productive participation. Conduct that fails to meet these values can be evaluated as irrational, unproductive, deviant, and pathological (Esposito & Perez, 2014). Mental health service provision is based heavily on biomedical concepts which pathologise conduct that deviates from functional and productive values (Moncrieff, 2010; Szasz, 1994). Pathologising family of people diagnosed as mentally ill has also been a domain of research within psychiatry (see Friedman & Friedman, 1970; Neill, 1990), with family frequently portrayed as generating and maintaining illness.

This research includes an analysis of how the condition of neoliberalism supported the consumerisation of mental health service provision and the formation of subject positions made available to family that advanced their responsibility within processes. The implications of neoliberal thinking and practices can be found in Chapters Six and Seven of this inquiry, exampled by State expectations for family and community to take on responsibility for *caregiving*, and through the rise of notions such as 'resiliency' in policy.

Summary

A poststructural position informs this thesis through using notions and principles developed by Foucault over his oeuvre. Discourse analysis in this thesis incorporates archaeological and genealogical components, discussed in the next chapter, with a focus on power/knowledge and the construction of subjects. Power/knowledge elucidates the constitutive and functional nature of discourse and possibilities for resisting certain subject positions within discursive practices informing iterations of family and whānau involvement, including iterations of *consultation* in mental health service provision. Liberal, social welfare, and neoliberal conditions are considered in analysis through their influence on the time periods analysed. Further elucidation of philosophical underpinnings and theoretical parameters, discussed in this chapter, is continued in the following chapter on the methodological concepts shaping the design of this study.

Chapter Three: Foucault's Methodological Tools and Their Relevance to This Inquiry

This chapter explicates the application of the philosophical and theoretical framework described in Chapter Two; the 'doing' of a Foucauldian inspired discourse analysis. Noted in the previous chapter, Foucault refrained from providing fixed methods for research, and used and/or developed tools from other philosophers to suit his analytical works. However, a tension arises from claiming that a discourse analysis is Foucauldian in nature without clear methodological guidelines and "at the same time satisfying the conventions of academic … research" (Graham, 2011, p. 1). One way to address this tension is by demonstrating congruence between the philosophical and theoretical framework and the inquiry through adaptation of the methodological approach to the research questions (Fadyl et al., 2013b; Hook, 2001). This entails discussion on how the works of Foucault (and other researchers following in similar footsteps) have been interpreted and applied to the research topic (Fadyl et al., 2013b) of family and whānau *consultation*.

This chapter describes the interpretation and application of the specific tools, introduced as theory in the previous chapter, and chosen for this inquiry to answer the research questions. *Consultation* in this thesis is problematised through a socio-political analysis of the constitutive and functional nature of discourse, offering a critique to the reader on how and why this practice may have taken its contemporary form. This thesis critiques the possibilities and constraints in current *consultation* practice through an historical analysis to elucidate that the obvious in "what is taken for granted is no longer taken for granted. To do criticism is to make harder those acts which are now too easy" (Foucault, 1994g, p. 456). Criticism in this thesis signifies elucidating possibilities for transformation within practices through visibility of the underlying rules shaping practices.

It could be argued that this inquiry falls under the remit of critical discourse analysis (CDA) when discussing possibilities for transformation. Certainly, there are many methodological tools available to CDA researchers, such as linguistics, historical, structural, and the formation of subjects (Tenorio, 2011), that resonate with the methodology of this thesis. CDA aims to identify power relations within and between groups and institutions that enable the legitimisation and de-legitimisation of discourse. However, a structural approach is commonly used in CDA to identify and challenge social issues; for example, inequality, through identification of how elitist structures, such as institutions, facilitate and maintain inequality for specific groups through language and text (Van Dijk, 1993). Possibilities for transformation arise through providing ‘findings’ that act as ‘truth’ claims and thereby take on an explicit position (Graham, 2011; Van Dijk, 1993). Using a CDA approach, for instance, might propose from ‘findings’ how discrimination functions for certain types of family through *consultation* practices and suggest specific changes to practice.

The present study casts a poststructural gaze on the socio-political field in which *consultation* is produced by identifying the functioning of discourse arising from (but not limited to) institutions using policy and law to shape practices. It differs from a CDA approach through avoiding the provision of ‘findings’ as ‘truth’ claims, and refrains from making claims about the intentions of authors, such as accusations of discrimination. Possibilities for transformation resulting from this inquiry arise not from arguing specific positions or findings, rather exposing dominate discourses and discursive conflict through a “liberation of thought” (Foucault, 1994g, p. 457). In other words, it aims to showcase for discussion how contemporary practices have been shaped by historical discourses to enable the construction of subject positions through relations of power/knowledge.

This inquiry critiques the contemporary practice of *consultation* through identification of historical, social, cultural, and political discourses shaping and constituting multiple subject positions, thereby enabling possibilities for subject liberation (Fadyl et al., 2013b; Tamboukou, 1999). This aspect of the inquiry aligns with Foucault’s research methods where he refrained from doing analyses from contemporary positions, and instead drew on historical sources to highlight shifts and discontinuities in understanding. Unlike the works of Foucault, this inquiry also analyses contemporary social cultural and political discourses, as employed and argued by Fadyl et al. (2013b).

The reasoning for the incorporation of present-day analysis is threefold. First, the shift from institutional to community care and the emergence of family and whānau *consultation* is relatively ‘new’ in its current form. This ‘newness’ influences the time periods available for genealogical exploration. Additionally, unlike Foucault’s exploration of larger topics (e.g., madness, discipline, and sexuality), this study focuses on the relatively specific practice of *consultation* within the MHA, 1992; hence, less data are available. Finally, the MHA, 1992 is in the process of being repealed and replaced. Analysis of emerging discourses alongside the historical analysis allows for discussion of what discourses have enabled and constrained regarding *consultation* and where contemporary practices may have the potential to be otherwise (Fadyl et al., 2013b). One may argue that contemporary practices are encompassed within a new rupture if significant transformations goes ahead to mental health law as claimed (see Ministy of Health, 2021, and the claims made within the discussion document). An analysis of emerging discourses also provides opportunities for future research concerning the topic of family and whānau involvement in mental health service provision.

As noted, this thesis draws from the methodologies employed by Foucault within his own research. Foucault played with multiple methodological attitudes in his own inquiries, that habitually developed through the research process itself (O'Farrell, 2005). The next section introduces Foucault’s notions and principles that are pertinent to this inquiry.

Archaeology and Genealogy

Foucault’s methodological attitudes/works can be separated into two main periods noted as archaeology and genealogy, demarcated by his book ‘Discipline and Punish’ (Foucault, 1977). His later works are sometimes seen as the development of a third ethical period explicitly encompassing the construction of subjects (O'Farrell, 2005); however, for this thesis, his later works are broadly situated within his ‘genealogical period’. Both archaeology and genealogy were used by Foucault as terms for extracting and analysing history in a way to note difference with the connotations of traditional historical analysis (Foucault, 1972; O'Farrell, 2005). One key difference of note is the principle of discontinuity that Foucault (1972) claimed is erased by general historians to provide a sense of continuity and thus progression. As a methodological principle, discontinuity acts as “an instrument and an object of research” (Foucault, 1972, p. 10) through providing limits and periods for discourse analysis. These limits are the ruptures from which discontinuity can be witnessed; for example, the rupture marked by the shift from institutional to community care. Discontinuity as a principle is also applied in this thesis to analyse contemporary social formations (discussed in more detail below).

Archaeology

In ‘The Archaeology of Knowledge’ (Foucault, 1972), traditional history’s truths are defined by what Foucault designated as significant monuments: key documents written by key figures, preserved and categorised to provide teleology and progressive human actions. In questioning this approach to historical analysis, archaeological exploration involves uncovering the conditions, the underlying rules, that enable discourse to be recognised as ‘truth’ (Bevir, 1999) from within historically distinct ways of seeing the world. Archaeology illuminates that which governs “how thinkers would think, how statements were made, and how discourse was formed, without directly intruding on the consciousness of the thinkers themselves” (Garland, 2014, p. 369). By rejecting a focus on authors and their intended meanings, documents/text, including those perceived as insignificant, become the focus of analysis to explore discursive formations (Fadyl et al., 2013b).

Foucault (1972) described the fundamental but generally unconscious codes by which people understand the world in different time periods as ‘epistemes’. He noted epistemological codes as defining individuals and practices through the way concepts are ordered, classified, and rationalised; the conditions that constitute knowledge (Bevir, 1999; Calvert-Minor, 2010). As an example, contemporary understandings of health compared to understandings 300 years ago would be different, as with understandings of consultation in the 1970s compared to 21st century meanings. Archaeology informs this analysis of *consultation* through examining and questioning the self-evidence of ‘truths’ that shape practices and construct subjects (Fadyl et al., 2013b) through an exploration of the historical contingency of concepts informing contemporary practices.

Genealogy

Foucault’s thinking concerning broad epistemological categories constituting knowledge and constructing subjects changed in the mid-1970s, culminating in a greater focus on power/knowledge, rather than epistemes constructing subjects (Bevir, 1999). Moving away from structuralist thinking on how rules and structures shape practices and construct subjects, Foucault explored and used genealogical notions developed by Nietzsche on modern power forms (Tamboukou, 1999). He proposed that a critical use of history could enable the identification of how dominating discursive systems construct subjects (Foucault, 1984b). *Consultation* with family and whānau as a practice is thus explored to identify the relational techniques of power that construct subjects, influence the possibilities of how they perceive themselves as subjects, and thus enable and limit what they can say and do (Fadyl et al., 2013b). Analysis of discursive formations provides the possible socio-political effects and functions of *consultation.*

In ‘Nietzsche, Genealogy, History’, Foucault (1984b) elaborated how the Nietzschean notions of descent and emergence guide genealogical analysis. Descent challenges the search for origins by uncovering practices as inventions and developments rather than a fundamental aspect of human nature. An analysis of descent encourages the analyst to identify practices as they are done without presuppositions of teleology or linear development, but as they were (Tamboukou, 1999). *Consultation*, in this sense, is explored to identify its many ‘beginnings’ arising from disparate functions that culminated in current practices.

Emergence describes the episodes when discursive concepts appear as a dominating force, either suddenly or through processes (Hardy, 2011; Tamboukou, 1999), as *consultation* appeared as a legal term in 1999 within the MHA, 1992. However, emergence does not suggest that *consultation* was ‘new’ in the sense of a practice and does not look for its intended meaning in the Act. Instead, emergence enables the identification of the relations and dominance of discursive power that enabled *consultation* to come into effect within its present form. Genealogy, thereby, identifies the numerous beginnings of *consultation* through descent and the power/knowledge struggles that shaped its emergence.

Archaeology and genealogy guided the research process through shaping the research questions and focus of the inquiry.

Inquiry Focus and Research Questions

The focus of this study is the identification and analysis of discourses at play in relation to family and whānau *consultation* under Section 7A of the MHA, 1992. It is concerned with the interrelationship between power relations through the construction of knowledge and the formation of subject positions for those involved in the practice of *consultation*.

Research questions that have aided analysis are:

1. What are the key historical and contemporary, social, cultural, and political discourses at play in the practice of *consultation*?
2. What relations of power/knowledge enable the generation of subjects?
3. What are the implications (constraints, limitations, and possibilities) for family and whānau and responsible clinicians arising from discursive practices?

Archaeological and genealogical notions and principles (tools) to answer the research questions were used within the research. Initially, archaeological analysis of data enabled the identification of the rules and conditions that support the formation of statements and discourse from within discourse itself (Bevir, 1999; Foucault, 1971). In other words, I explored how objects are constituted through what can be said and by whom to enable the materialisation of knowledge as practices. Then, genealogical analysis of the data explored discursive practices within and between various power forms, shaping, enabling, limiting, and constraining conduct through available subject positions at different historical moments (Foucault, 1977, 1978). Specifically, I analysed how relations between power forms promote certain types of conduct through the generation of subjectivities, by external means and self-formation (Foucault, 1994h). The purpose in this study is to make visible, and subject to critique, many of the assumptions underpinning current *consultation* practices. The study concludes by exploring the implications of discursive practices on family and whānau as they engage in and/or refuse iterations of *consultation*; thereby, impacting the person undergoing compulsory assessment and treatment (Foucault, 1994g). The following sections explain how archaeological and genealogical notions and principles were used to guide the research.

Examining the Rules and Conditions of Discourse Forming *Consultation*

Archaeological analysis in this thesis draws significantly from the book ‘The Archaeology of Knowledge’ (Foucault, 1972) and ‘Orders of Discourse’ (Foucault, 1971), Foucault’s inaugural lecture at the Collège de France, as both sources explicate methodological principles and notions of archaeological analysis.

To begin the process of identifying, scrutinising, and critiquing discourse, Foucault (1972) noted the most basic element of discourse for analysis as the statement and text. Text is a source of data for analysis as it is comprised of statements. Statements operate within a field of relations, their context arising from signposting which defines their function. Statements may contain the same words in the same order but can have different meanings, depending on the context in which they are stated, and associated cultural understandings (Fadyl et al., 2013b; Graham, 2011). For example, “yes, I hear voices” spoken between thieves could function to hinder the robbery of a house or be spoken between a person with a hearing impairment and an audiologist reporting the efficacy of a hearing aid. In answer to a mental health assessment question, from a Western perspective, “yes, I hear voices” might indicate a symptom of auditory hallucinations, the potential diagnosis of psychotic illness, and function to enable treatment (Heriot-Maitland, 2011). From a Māori perspective, “yes, I hear voices” may indicate Matakite tohunga (spiritual gift), whakapapa tūpuna (contact with ancestors) or mate Māori (Māori illness) (Taitimu et al., 2018) enabling a variety of potential functions.

Although statements are more easily elucidated through the spoken or written word, statements also appear in other forms, such as images, objects, and the arrangement of spaces (Fadyl et al., 2013b; Graham, 2011). Physical objects, such as the straitjacket, often depicted within the space of the padded cell, illustrate a historical understanding of madness as predominantly dangerous, and through the absence of both objects in contemporary mental health practices can represent potential progression in service provision. The image in posters of clients, family and whānau, and clinicians together in friendly conversation, as an example, can represent a sense of *partnership*, or again the idea that mental health service provision is very different from the past.

Physical objects, architectural spaces, images, the written and spoken word appearing as statements need what Foucault (1972) defined as a referent, the ‘thing’ being referred to within communication. In this regard, ‘things’ are the objects formed and shaped by discourse as found within statements. As well as containing the referent object, statements function through enunciative modalities, concepts, and strategies. These four elements formed by discourse used to “conceptualise and communicate end up producing the very ‘things’ or objects of which we speak” (Graham, 2011, p. 6). In this thesis, statement analysis to identify these four elements was the first step in identifying the discourses at play in the practice of *consultation*.

Object Formation

Identifying the rules that shape their existence, Foucault (1972) suggested identifying objects through mapping their surfaces of emergence, authorities of delimitation, and grids of specification. In this thesis, family and whānau are palpable examples of an object, repeatedly emerging in statements as *consultation* is about family and whānau involvement. Surfaces of their emergence, that is, where they materialise as an object, include legislation, privacy policy, and the clinical encounter, as examples in this thesis.

How and where they emerge, shape their formation as objects, defining their function, in part, through authorities of delimitation (Foucault, 1972); that which defines and limits family and whānau *as* family and whānau contextual to mental health service provision. In this thesis, those that have established family and whānau as important objects within mental health practices include the broader institution of medicine, health, and advisory groups for policy makers. Grids of specification for family and whānau in this thesis are the different iterations within classification systems family and whānau can take (Foucault, 1972). These include whanau (without the macron), whānau, family, as detached forms, proposing distinctions between Māori and non-Māori or 'family/whānau' signifying similarity. Family and whānau, as objects for intervention, can also be categorised in other ways, such as dysfunctional and burdened, enabling practices of inclusion and exclusion. Distinction between 'family' and 'whānau' is considered important in this thesis, as explicated within the discussion in Chapter Eight.

Foucault (1972) noted the importance of identifying the relations between surfaces of emergence, authorities of delimitation, and grids of specification to identify discursive formation. He noted that objects were made visible through complex relations "established between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterization" (p. 49). An example from this thesis is the constitution of family and whānau functioning as an object through relations between privacy and confidentiality law, human rights, and the concept of caring.

The Right to Speak

Statements function through the level of 'truth' ascribed to them via attached status. Enunciative modalities identify the author of the statement and their right to speak on a specific object. Authors are generally not individuals (names); rather, the institutions or organisations to which they are attached. Speaker privilege provides groups and individuals the perception of being trusted to speak on specific topics within defined limits (Foucault, 1972; Hook, 2001). Speakers enable text to be categorised and differentiated from other texts, as well as establishing hierarchical relationships between texts. The function of the author also enables the production and circulation of specific discourses qualifying the statements contained therein to function (Foucault, 1984d).

In this thesis, the institution of psychiatry is privileged to speak broadly on a biomedical understanding of madness. Generally limited to clinical perspectives, psychiatric texts can be categorised into systems, such as research, policy, and law, that reciprocally validate statements through their relations (Moncrieff, 2010). A biomedical understanding of madness is propagated through other surfaces of emergence, such as through media forms (e.g., news, literature, film) to depict and normalise psychiatric discourse within the wider general population (Venkatesan & Saji, 2019). The lived experience of madness, including family and whānau experiences, qualifies a different author that may concur, compete, and challenge biomedical and other understandings of madness.

Concepts

The arrangement of statements in specific systems, as according to the rules that enable their order or succession, was noted by Foucault (1972) as signifying concepts. Concepts self-validate through relations between different domains. For example, the concept of mental disorder is formed through rules related to symptoms and diagnosis. It is validated through statements that have been constructed, modified, and arranged over time through the institution of psychiatry, such as within the 'DSMs' produced by the American Psychiatric Association. Mental disorder functions within mental health service provision and other domains, such as pharmacology, strengthening its validity as a concept (Moncrieff, 2007). *Community care* is a dominant concept in this thesis constructed and validated through discourses such as psychiatry and human rights, enabling the concept to function as a strategy.

Strategies

Foucault (1972) noted the arrangement of concepts, grouping of objects, and types of enunciation enable the formation of broader theories and themes, otherwise known as strategies. Strategies reorganise the discursive field through translating statements from one theory or theme to another, enabling the formation of new concepts, and the acceptability (or not) of discursive practices (Jansen, 2008). As theories/themes are wide ranging they offer possibilities for what Foucault (1972) noted as points of diffraction; the contradictions, oppositions, and alternate possibilities of interest for analysts. For example, the philosophy of personal *recovery* developed by the service user movement in the 1970s/80, remonstrated against forms of objectification and oppression of people experiencing mental illness from the institution of clinical psychiatry (cf. Deegan, 1993; O'Hagan, 2014).

Recovery philosophy has been co-opted and modified into clinical practices, such as through the development of *recovery* as a model which uses stages and rating tools (cf. Andresen et al., 2006). Although, in the case of Andresen et al. (2006), it has been used to “realize the vision of recovery-orientated mental health services” (p. 972), the use of stages and rating tools has the potential to objectify those using services by clinical staff. Objectification may arise from labelling service users’ differing levels of engagement within their *recovery* as depicted by stages. As a strategy to support wellness, *recovery* models provide a discursive contradiction, a point of diffraction with *personal recovery* approaches in the overarching strategy of *recovery* (see Chapter Seven for further discussion).

Principles Facilitating Critique

Doing a Foucauldian analysis entails the questioning of that which has shaped the analyst’s worldview on a specific research area, especially if the analyst has significant prior links to the research topic. As noted in the previous chapter, the history of an idea, such as a health response to madness, is normatively depicted as a rational progression enabled through a continuity and refinement of practices (Foucault, 1972). Foucault (1971) discussed four key principles underlying archaeological and genealogical analysis that facilitate critique of progression narratives: reversal, discontinuity, specificity, and exteriority.

Principle of Reversal

The critiquing analyst needs to break with much that was previously perceived as natural: the principle of reversal. Foucault (1971) noted that in order to disrupt the relationship, “we must rather recognise the negative activity of the cutting-out and rarefaction of discourse” (p. 22), through discovery of that which historians have manipulated or hidden. One approach Foucault discussed is to identify the rules enabling the procedures of exclusion and limitation; broadly, that which cannot be said, and that which is repeated, respectively.

Reversal entails identifying procedures of exclusion, such as through the practice of prohibition, on what can be said about objects, who has the right to speak, and what is deemed rational (Foucault, 1971). As an example, prohibition of what can be said about specific objects can be found through the relation between texts that have been sanctioned versus other texts. Statements from family and whānau, such as contained in government endorsed national inquiries or newspaper articles are subject to exclusion through editing out perceived irrationality. Submissions on proposed bill changes, inversely, are unlikely to be redacted. Exclusionary procedures involve detecting the knowledge that supports statements and discourses to function, and whether the knowledge is legitimised or not by institutions (Fadyl et al., 2013b). In Chapter Eight, the principle of reversal is explored through the suppression of Te Ao Māori (worldview and cultural practices) qualifying the domination of Western discourses.

Procedures of limitation in this thesis are concerned with internal rules of discourse that limit what can be said through how knowledge is classified and distributed. Foucault (1971) noted commentary, the author function, and disciplines as procedures of limitation. Commentary acts to reproduce the same statements, recirculated in texts to support legitimacy. As an example, early texts on the importance of family and whānau as *partners* within community mental health service delivery was repeated in policy (Ministry of Health, 2000), advisory group recommendations (Mental Health Commission, 1998), and in guidelines to the MHA, 1992 (Ministry of Health, 2012a). Commentary as a procedure of limitation is explored through the identification of the conditions that enable certain statements status through hierarchical classification (Foucault, 1971).

Whereas enunciative modalities signal the legitimacy of statements relative to the position of its speaker, the author function limits what can be said through relations between text and people, groups, and institutions. Authors represent a group of discourses that are coherent (Hook, 2001), such as psychiatry. The author limits what can be said contextual to the original meaning taken by the author. For example, the *responsible clinician* in *consultation* will speak within psychiatric discourse, such as symptoms, diagnoses, and causative factors that align with a biopsychosocial frame of reference. Certain things would be difficult to say for the *responsible clinician* to be taken seriously; for instance, psychosis caused by extra-terrestrial control. However, limits are not fixed, as shifts in cultural understandings of madness can challenge previous explanations, such as the incorporation of the psychosocial within the biomedical model in the 1970s that expanded the framework of psychiatry (Engel, 1977) and the integration of Te Ao Māori (worldview), as explored in Chapters Seven and Eight. Analysis of the author function involves exploring how knowledge is constructed to constrain and shape behaviour, enabling possibilities for subject positions and privilege (Fadyl et al., 2013b; Foucault, 1971; Hook, 2001).

Specific disciplines act to limit what can be stated through enabling the production of new statements from within its own system of rules and definitions (Foucault, 1971). The discipline of psychiatry, as an example, contains tools, such as the identification and categorisation of symptoms, that can be used to create new diagnoses, as long as they follow the rules of psychiatric discourse. Analysis of the relations between statements and disciplines enables the examination of "what criteria the statement or text must fulfil to be considered as belonging within that discipline, in turn helping to make visible how that discipline serves to limit what can be said" (Fadyl et al., 2013b, p. 486).

Genealogy: Power and the Functioning of Discourse

The Principle of Discontinuity

To see discourses as events and practices dispersed, accidental, conflicted, and non-linear (Foucault, 1972), requires the analyst to move away from analysing historical events from within contemporary socio-political and cultural understandings of the past (Hook, 2001). Instead, present practices are interrogated through an exploration of the past which have enabled and shaped the current values and rules of contemporary practices (Dreyfus & Rabinow, 1982, as cited in Hook, 2001). By doing so, the analyst can explore and identify what is currently occurring and what that occurrence is; therefore, employing a 'history of the present' (Hook, 2001; Tamboukou, 1999). Application of the principle of discontinuity in this thesis involved questioning the authority and 'truth' attributed to texts from different historical periods and sources, enabling me to make visible things that are taken for granted (Fadyl et al., 2013b; Hook, 2001) concerning family and whānau involvement in mental health service delivery. A broader, lateral mapping, as opposed to a linear one that is limited to the practice of *consultation* only, can exploit "the gaps and shortcomings of a given discourse… systematically demonstrating its contradictions and discontinuities" (Hook, 2001, p. 26).

The Principle of Specificity

Foucault (1971) noted the relationship between the textual and the material aspects of discourse. Specificity, as argued by Hook (2001) enables the analyst to consider the *"discursive effects* of the material, and *the material effects* of the discursive" (p. 30). Specificity aims to reduce generalisations that could arise from textual analysis only. The principle enables the analyst to see discourse as human practices contextual to a specific period of time and from within a specific cultural view of the world, as examples. From this perspective, it is difficult to see discourse as representing a reality, or a 'truth', as it is specific to that which enabled its construction. Its employment in this thesis is through analysis of the relationship between policy shaping practices and practices shaping policy. As an example, in this thesis, critique from family and whānau concerning their lack of inclusion in service delivery has (in part) shaped policy to promote inclusiveness which (in part) has shaped practices concerning inclusion. However, the notion of inclusion is not static; rather, signals different practices across time and from within differing cultural understandings.

The Principle of Exteriority

Exteriority supports the analyst to identify how discourse functions as practices instead of attempting to identify meanings and ‘truth’. Noting that “*everything* is never said” (Foucault, 1972, p. 134) promotes the examination of why certain statements operate in practices to the exclusion of other statements. The analyst, therefore, aims to identify how statements function through discursive framing to construct a specific view of the world, enabling possibilities for thinking and acting, and the generation of certain subject positions (Foucault, 1972; Graham, 2011). Exteriority is applied in this thesis through identifying what statements produce; the possibilities for family and whānau and *responsible clinicians* arising from the discursive framing of *consultation* as a practice. Identifying the possibilities thereby enables the identification of what is deemed impossible or unreasonable; and thereby other possibilities for practice (Foucault, 1972). Fadyl et al. (2013b) suggested adaptation of this principle to the research question, as the scope of how discourse functions is extensive.

In this thesis, exteriority is employed to identify relations between power/knowledge forms which act to generate subject positions. For example, the MHA, 1992 uses the notion of the *principal caregiver*, signifying practices of caring for the person being examined by family, but also constructing the possibility for hierarchical positioning over other family members relative to decision making (see Chapter Eight for elucidation of this term). In The ‘Birth of Biopolitics’, Foucault (2008a) suggested that power operates in a multiplicity of domains within different contexts, with analysis thereby focused on the relations of power concerning a specific topic. As noted in the previous chapter, power is not a concrete entity or held by institutions (Smith, 2000); rather, power operates relative to the construction of ‘truths’ and the generation of subjects (Tamboukou, 1999). Four power/knowledge forms are applied in the analysis of data to identify how its exercise constructs subjectivities through shaping desired conduct, now discussed in further detail.

In ‘Discipline and Punish’, Foucault (1977) explicated the notion of sovereign power through the monarchy’s right to take life or let live, public torture, and execution. The activation of sovereign power, in this sense, occurred when it came under attack. Thus, absolute rules of law could be harnessed when required (Smith, 2000). And yet, Foucault (1994d) noted how political sovereignty moved beyond monarchical forms of authority into the social body, a resource that connected administrative and political controls with the family. A deductive power exploiting fear, “a right of seizure: of things, time, bodies, and ultimately life itself… in order to suppress it” (Foucault, 1984c, p. 259).

In this thesis, sovereign power is analysed not as an absolute force, rather as an integration of power and violence, as suggested by Lilja and Vinthagen (2014). As with criminal law, which draws from the function of sovereign power to exclude members from society through imprisonment or immigration policy (Stumpf, 2006), the MHA, 1992 provides the possibility to seize the body through involuntary hospitalisation, commit violence through restraint and seclusion, and suppress perceived symptoms of mental disorder through compulsory medication regimes. The *proposed patient* and *patient* are constructed as objects for potential and actual seizure enabling possibilities for disciplinary techniques.

Foucault (1978) delineated sovereign power as incongruent with forms of power operating through techniques as opposed to monarchical rights, through normalisation rather than law, and through control rather than punishment. He prescribed the need to “break free from… the theoretical privilege of law and sovereignty, if we wish to analyze power within the concrete and historical framework of its operation” (Foucault, 1978, p. 90). Sovereign power is thus positioned in this thesis as an administrative resource operating ‘behind’ the productive functioning of disciplinary power (Deacon, 2002). A cyclical position is taken up in this thesis where law operates to enable techniques of surveillance and control (Smith, 2000), with individualising practices sanctioned as law (Foucault, 1994h). This inquiry aims not to privilege; rather, view law as a potential instrument available to the techniques of disciplinary power through authorising and mandating the normalisation of discourse and using the threat of and actual violence when required. Resistance to a deductive and punishing power is analysed through possible challenges within law itself, such as rights and codes of practice (Lilja & Vinthagen, 2014; Smith, 2000).

Disciplinary power in this thesis materialises as the techniques and strategies that control and shape bodies into individuals that meet certain needs. As individuals, people are trained in appropriate behaviours to fulfil specific roles and enable the achievement of specific outcomes. Family, for example, can be trained to monitor symptoms and undesirable behaviours occurring within the home and to report concerns to clinicians (see Chapter Five). Education and training of family members to fulfil specific needs, such as monitoring, has enabled the construction of family as a *partner* of mental health services (see Ministry of Health, 2000). From a socio-political gaze, subject positions emerging from the objects of family and whānau are identified from discursive practices that shape conduct through normalisation and formalised through law. The *principal caregiver* appearing in the MHA, 1992 signifies family and whānau functioning in relations with the *responsible clinician*, enabling techniques which normalise psychiatric concepts and strategies. Subject generation, in this thesis, is also explored through the exclusion of certain 'others' (in regard to desirability), such as deviant parents. In this thesis, undesirability can include family and whānau categorised as harmful to the functioning and aims of mental health service provision and the notion of caring, such as the "parent who models anti-social behaviour" (Mason, 1988, p. 40).

Through analysis of texts and practices, this thesis aims to explore the locations and processes of *consultation*; for example, how bodies are partitioned and distributed within practices that enable examination (Foucault, 1977). As an example, fixing individuals in case notes, increasingly available through digital forms, enables possibilities for hierarchical observation, with 'texts' becoming the 'cells' in promoting conformity (Manokha, 2018). Notes on family and whānau, when accessed, provide opportunities for categorisation and possibilities for opportunities or constraints for inclusion in practices based on category. This notion is referred to in Chapter Five in research on non-European populations.

Hierarchical observation, as a technique that promotes and discourages certain behaviour, is investigated to expose the underlying values and rules informing the shaping of conduct. The normalisation of discursive practices is considered through relations between external manipulations and internal configuration arising from recognition of the self as a site of knowledge (Foucault, 1994h). Resistance to techniques and strategies of discipline is explored through examples of practices that either challenge the shaping of conduct or use the tools of shaping in unintentional ways (Lilja & Vinthagen, 2014). Examples may take the form of complaints, refusal to participate, or using educational material aimed at shaping behaviour for advocacy. Resistance to *community care* by organised 'care giving groups' provided an example of how the circulation of emerging dominant discourse provides opportunities for resistance (see Chapter Six).

Conduct of conduct on a larger scale, biopower, through governance of specific populations, is regarded as a productive form of power concerned with the overall welfare of its members. The organisation of populations occurs through administrative practices that promote, shape, measure, and ultimately normalise behaviours that support productivity and health on a larger scale (Foucault, 1978; Taylor, 2011). At the international level, health strategies developed by the WHO promoted mental health as equally important as physical health from the 1950s, encouraging a range of public health services including inpatient and community-based care. The construction of day hospitals, out-patient clinics, and the notion of rehabilitation for mental illness are examples of techniques and strategies disseminated to world regions to improve the general welfare of populations (WHO, 1962). A broader mapping of events, such as this example, highlights possibilities for the construction of *consultation*.

Relations between biopower and disciplinary power are considered in this thesis through how broader population norms are circulated and taken up through the internal constitution of subject positions (Foucault, 1994h), such as how family members positioned themselves as *carers*. Analysis of biopower in this thesis is, therefore, through identification of the tools, techniques, and strategies exercised as forms of governance. Research, the development of models, and educational material, as examples, within and related to practices of *consultation*, are explored. Broader, lateral means of circulating truth claims, such as through the media, are also considered, as is pastoral power that enables the dissemination and translation of knowledge.

In applying pastoral power, the analyst identifies sites for translating law (sovereign) and norms (biopower); thus shaping the desired conduct from the macro to the micro, from populations to bodies (disciplinary) (Martin & Waring, 2018). As noted by Foucault (1994h), the function of the religious pastor in the 18th century shifted from spiritual salvation to physical health and *wellbeing*. However, the techniques and strategies employed, such as the promotion of self-disclosure, examination, monitoring, and shaping, remain the same (Winch, 2006).

Pastoral power as a technology of governance is explored through how certain subject positions take on the pastoral role to translate knowledge and shape conduct, such as health clinicians. For example, clinicians may need to translate the concepts and values of specific discourses into more easily understood practices for family and whānau (Martin & Waring, 2018), such as describing mental ill health as stress (WHO, 1953) (see Chapter Five). The exploration of pastoral power in this inquiry is not, however, limited to a top-down (State and institutional) imposition on others. This thesis also explores other possibilities that individualise (on bodies) and totalise (on populations) (Foucault, 1994h). For example, mental health service users in the 1970s and 1980s who critiqued mental health service provision of that time, acted as a form of resistance through the construction of the *service user movement* (Chamberlin, 1990; Crossley, 2002). As a movement it circulated ‘truths’ arising from personal experience to promote health in a system described as oppressive and dehumanising (Deegan, 1991, 1993). Advocates from the movement who took on positions within mental health services, and who were provided opportunities for the translation of emerging norms, shaped service provision from a service user perspective (cf. O'Hagan, 2001). Thus, in a sense, these advocates exercised a totalising form of pastoral power to shape service provision in Aotearoa New Zealand through translating and promoting the adoption of *recovery* philosophy into services and policy (cf. Minister of Health, 2005) and guidelines to law (cf. Ministry of Health, 2012a), as explored in Chapter Seven

In this thesis, law is viewed as enabling the generation of norms dispersed amongst the general population, and enacted into practises that shape bodies through subject positions that translate knowledge into the context of targeted sites. The operation of pastoral power is, therefore, explored and analysed relational to sovereign, disciplinary, and biopower in the construction of objects and subject positions. Resistance to pastoral power is explored in this thesis through opportunities of counter-conduct, enabling tensions between and within discourses and subject positions (Rust, 2021). Practices arising from a Western medical gaze concerning auditory hallucinations as a symptom of psychosis can be countered with a Te Ao Māori (worldview) gaze of whakapapa tūpuna (contact with ancestors). Tensions may arise between the positions of psychiatrist and kaitakawaenga (cultural worker) in the distribution of knowledge.

Summary

This chapter has defined the limits of the methodology through a discussion on the application of the theoretical framework. The process and procedures employed, the design of the study, is now explicated.

Chapter Four: The Design of the Study

This chapter articulates how the theory and methodology, discussed in the two previous chapters, formed the study's design for the analysis of text broadly concerning *consultation*. Discourse analysis principles are further developed to explicate the methods of choosing, collecting, and analysing texts to answer the research questions. In keeping with Foucault's (1972) dislike of linear explanations, the process of designing this research thesis has been an organic experience of growth, mutations, impasse, and regrowth. Study design occurred throughout the whole research process; fragmented periods of intersected reading, thinking, analysis, and writing, contributed to the process. Also, in accordance with the notion of emergence (Foucault, 1984b), there were many 'starting points' shaping the materialisation of this thesis through thinking differently.

Thinking Differently

Thinking about the research topic was one of the reoccurring starting points for this thesis. It was an experience of broadening out, narrowing down, and sideways thinking on the topic, amid a deepening comprehension of 'Foucauldian thinking' by Foucault and other writers pertinent to my research. Of significance, was the process of seeking to think differently about the topic. In 'The History of Sexuality: Volume 2', Foucault (1984a) noted the importance of seeing the boundaries of knowledge to see things in a new light. This occurrence, through perceiving changes in one's thinking, was demonstrated, for example, through the growing awareness of *consultation* as a 'problem' arising from practices constructing mental illness, family and whānau involvement with mental health service provision, and legal processes. Problematisation enabled thinking about links between the historical dimensions of knowledge and contemporary practices within the design of the inquiry (Tamboukou, 1999). I wanted to see how *consultation* was a 'problem' in contemporary practices through historical processes and practices that had shaped it into what it was. Another key aspect to thinking differently was the recognition of the relationship between thinking and action, by 'seeing' thinking materialise as practices (Frederiksen et al., 2015; Hook, 2001). Methodological principles pertinent to the design of the study, arising from thinking, are outlined below.

Criteria for Text Selection for Analysis

In ‘Nietzsche, Genealogy, History’, Foucault (1984b) signified the need for “a vast accumulation of source material” (pp. 76-77) when doing a genealogy. A key criterion for choosing texts was whether it related to the focus of inquiry concerning family and whānau ‘involvement’ in mental health services as conditions of possibility for *consultation* (and its various iterations) as well as ‘actual’ *consultation* represented as Section 7A. I accessed hundreds of texts through Te Rua Mahara o te Kāwanatanga (Archives New Zealand), Te Oohomauri o Kirikiriroa (Hamilton library), and online websites as a starting point (discussed further below). Three time periods of analysis were configured during the exploration of texts at the start of my research with further texts identified throughout the research journey. The exploration of different time frames reflected the principle of discontinuity through recognition of the ruptures/significant shifts in practices, the connections and lack of connections between discourse (Hook, 2001). Application of this principle helped me to identity that there was no progressive ‘plan’ for mental health service provision, as sometimes outlined in documents (cf. Mental Health Commission, 1998) citing development and evolution.

I had initially believed that the shift from institutional to community-based practices had occurred in Aotearoa New Zealand from the 1980s to the turn of the century. Through my initial scoping of text, I discovered that the shift had begun much earlier, which helped me resolve the boundaries of my construction of the first period of analysis. Texts confirmed this period (1950s–1970s) as a significant rupture detailing the shift to community-based practices with thinking of family in ways that enabled services to intervene on family and provide initial conditions for *consultation* as a practice to emerge.

The second period of analysis from the mid-1980s was a second rupture where significant critique of community-based practices emerged and provided the conditions for family agency and responsibility to materialise; and, thereby, possibilities for iterations of *consultation* to occur. The third period of analysis focused on current thinking and practices, and provided possibilities to explore how historical discourses had actuated the way family and whānau were consulted and therefore identify other possibilities.

In keeping with Foucauldian discourse analysis, to provide a sense of cohesion within my study I wanted to identify relations between knowledges, practices, and the constructed subject positions from the interrelationship of the three. These time periods supported but did not fully limit the identification of texts, as I also discovered texts outside of these three time periods that provided context to my analysis.

I have presented these periods in chronological order; however, such presentation does not intend to provide a sense of unity or progression within changes occurring to family and whānau in relations with mental health service delivery and *consultation*. The depicted ruptures within each period of analysis signify a reflection of social and cultural changes (Buus, 2001) occurring through conditions of possibility, rather than through a grand design and plan. An example can be seen with the first period of analysis from the 1950s to 1970s where the inclusion of family emerges through censorship and critique of family, rather than notions of their involvement being 'right' or helpful within the plan of deinstitutionalisation.

In his last works concerning the notion or 'experience' of sexuality, Foucault (1984a) identified the interrelationship between the following three axes of that which constitutes the experience: "(1) the formation of the sciences (savoirs) that refer to it, (2) the systems of power that regulate its practice, (3) the forms within which individuals are able, are obliged, to recognize themselves as subjects" (p. 4). This notion supported text selection through identifying the 'experience' of family and whānau involvement in mental health service provision[8], shaped by law and expertise, with a specific focus on *consultation* or conditions enabling iterations of *consultation*.

Three main approaches were used to support text selection. I identified texts from a 'top down' approach, such as international and national guidelines, policy, and 'expert' professional and clinical knowledge that had constructed mental illness, service provision, and critique. I also identified texts from a 'bottom up' approach, such as the voices of family and whānau and those using services as individuals and as collectives, such as through non-government organisations. Finally, I identified texts from what I see as the 'middle', such as through media reporting and academic research, although arguably these could represent both 'top down' and 'bottom up' depending on authorship. From within these approaches, I identified texts that were dominant, produced, and (re)circulated through a variety of surfaces and texts from the margins of what was possible to do and say within reach of the three epochs.

---

[8] The 'experience' signified the presence and absence of family and whānau.

My research questions aided a focus on experiences through choosing texts that supported identification of discourse and its function, witnessed through relations of power/knowledge and the implications arising from constructed subject positions. Keeping the context of a text within its time and place supported integrating the principle of specificity into the study. Specificity involved identifying the practices which continually constructed the notion of family and whānau involvement and *consultation* as practices. Specificity is seen in this study through noting how family and whānau and others emerge and play 'parts' in practices. In a similar vein, the principle of exteriority was integrated into my study through analysing texts that identified the conditions that made things possible, thereby looking for the possibilities for discourse to emerge.

The write-up in the form of analysis chapters was organised by the time periods identified. For each analysis chapter a larger text (document) acted as a thread within and between each chapter and supported a focus on the intersection between knowledge, and how groups (systems) used that knowledge in practices which generated or constructed subject positions. As an example, 'The community mental hospital' (WHO, 1953) provided a thread in the first chapter of analysis through providing the 'thinking experience' (Rose, 1999) of the shift from institutional to community practices that was occurring within the 1950s. Texts identified from Aotearoa New Zealand identified the 'doing' of early iterations of *community care* in the 1960s and 1970s; the systems and processes enabling the materialisation of thinking (i.e., outpatient clinics) and the consequent construction of subject positions (i.e., family as sick – see Chapter Five). Texts were thereby chosen for analysis that demonstrated the function of discourse within the time periods analysed, and the relations between thinking and doing.

Texts were selected from different worldviews; for example, Western and Te Ao Māori, mainstream and feminist, and selected as examples to demonstrate relations between dominant and marginalised discourse. The principle of reversal was embedded into my research through exploring the underlying rules that functioned to privilege and subjugate texts and practices, and thereby identify what was marginalised or missing. However, as discussed in the introduction, coming from the position of tangata Tiriti, I acknowledge the limitations of my study design when analysing from my Western position texts concerning or written by Māori. To overcome this limitation, reading texts written by Māori supported me to identify unconscious bias from a Western perspective in analysis as well as attending to feedback from my supervisors and tangata whenua aiding my analysis. My reading and analysis of texts written by and concerning Te Ao Māori (worldview) is discussed further below. Another consideration was analysing texts from a feminist perspective as a male. Reading on the subject of males learning about and being resistant to feminism supported me to reflect on male privilege and my potential resistance to feminist notions when analysing text from within this position. Texts that I found helpful included research by Pleasants (2011) and Webber (2005) that explore notions such as male privilege and resistance to privilege.

Gathering Texts

Texts were gathered from online websites, Te Oohomauri o Kirikiriroa (Hamilton library), and Te Rua Mahara o te Kāwanatanga (Archives New Zealand). Texts were grouped into the three time periods, noted above, with texts outside of these times grouped as contextual data.

Searching for texts was done through a variety of methods. Keywords and subject searches in databases and search engines, accessing archived magazines and newspapers from the library, and accessing historical text through Archives New Zealand were the main methods. ‘Family, whānau, whanau, relatives, compulsory assessment and treatment, hospitalisation, incarceration, psychiatry, madness, mental illness, mental disorder, *consultation*’, were the key words and phrases used interchangeably as a starting point to identify texts. These words were chosen as befitting the focus of the analysis but did not limit identifying data as other search methods were used, and therefore were not privileged.

Policy, commissioned documents, inquiries and reviews, and newspaper articles were accessed through government websites, the web (google search), and specific data bases; for examples Newztext. Magazines and newspaper articles were also accessed through Te Oohomauri o Kirikiriroa (my local Hamilton library). Identification of one document sometimes led to another; for example, ‘Looking Forward: Strategic Directions for the Mental Health Services’ (Ministry of Health, 1994) cited the Mason report (Mason, 1988). Keywords as noted above, departments, and subjects were used when appropriate to narrow searches, as with Newztext data base and Te Rua Mahara o te Kāwanatanga (Archives New Zealand). Many documents that I would have liked to access from Te Rua Mahara o te Kāwanatanga were inaccessible, classified as sensitive material, which was a limitation of this research.

Larger texts were chosen as a thread within the data analysis chapters. These texts were chosen as they represented significant discursive ruptures in the time periods analysed, and enabled critique of a unifying and progressive history (Foucault, 1972). In Chapter Six, for example, the Mason (1988) report provided text to question a progressive evolution of mental health services through the shift from institutional to *community care*. These larger texts acted to identify the problematisations of family and whānau involvement in mental health service delivery and practices of *consultation*. These texts also supported the identification of other texts, dominant and marginalised, by identifying discourses either repeated in other texts or less visible or missing. In this sense, dominant statements and discourse were visualised as the 'hub' and less visible, marginalised statements and discourse as 'spokes' coming off from the 'hub'.

Texts were grouped under five headings and saved into files under the three-time periods for analysis:

1. Texts that acted to guide and regulate practices including legislative Acts, policy, guidelines and supporting documents to policy or government, such as reports, inquiries.
2. Texts from academic research.
3. Texts from newspaper and magazine articles reporting on relevant subject matter.
4. Texts from websites, such as non-government organisations.
5. Texts documenting experiences written by family and whānau, people using services, clinicians or service providers appearing in submissions to legislation changes or within newspapers.

Further file categorisation under these occurred to support the organisation of the data. Endnote was used for managing references.

Processes of Analysis

Texts analysed in this thesis appear in centre-alignment with a footnote and as a footnote if not directly quoted. Supporting scholarship is found as in-text citation, with the source information in the reference list at the end of the thesis. The processes of analysis changed throughout my research, as the 'doing' of analysis supported my understanding. Hence the process used for analysis of the 1950s to the 1970s period was modified by the time I started analysis for the period mid-1980s to 2000, and again for the third period from 2017. I found this organic way of working acceptable based on the notion of the toolbox approach (Foucault, 1972; Graham, 2011; Tamboukou, 1999) in that as my understanding grew, I was able to adapt and play with the tools I was using for analysis. However, archaeological and genealogical notions, as discussed in the previous chapter, were the foundations of analysis to ensure that my research remained within the accepted boundaries of a Foucauldian discourse analysis.

Texts were read to gain a superficial overview and those texts that looked promising were saved for re-reading. On a second reading, key statements within the text were highlighted. A third reading of text was used to identify objects, potential subject positions, enunciative modalities, concepts and strategies, as suggested by Foucault (1972) to identify statements and discourse. Excel and word documents were both used to support analysis. In exploring data for the first time period (1950-1970s) of analysis, I played with text in tables, breaking it down according to archaeological notions to identify possible discourses and subject positions. The below example, a snapshot in time at the start of analysis, was of a newspaper article written in 1971 (Table 1).

Table 1.

Breakdown of Text

Details	**The *Press* newspaper article: “One in five mentally ill”. Ref: 1J**
Object formation	Relations between society/social relations and mental illness. Relations between mental and physical illness.
Objects	Population, mental illness, money, wife, mothers, men, husband, marriage.
Surfaces of emergence	Newspaper, Northland Association for Mental Health.
Authority of delimitation	Medicine/health.
Grids of specification	**Population**: “discard the view that mental illness was something to be *ashamed* of”. “*Everyone* of us has a breaking point, and today’s *society helps us to that*”. “Where the cows are healthy, but the *people are crazy*”. “That is why everyone should have a d*ecent emotional education*. That way we may get better marriages in the next generation”.

Details	**The *Press* newspaper article: "One in five mentally ill". Ref: 1J**
	"Psychologically we are grossly sick but physically we are well off". **Women**: "The New Zealand *wife* was in a state of *slavery*". There are four times as many *mothers* attending the outpatients department as any other type of patient". "...advocated day centres where *mothers could leave their children* for hours or days". **Men:** "Most New Zealand *men are emotionally defective,* but it is because the *husband* just doesn't realise what he is doing.
Enunciative modality	Medical superintendent Kingseat hospital.
Concepts	Promotion of mental illness as common place within the population - generated by society and relationships. Husbands and children cause women's experience. Women are slaves to their husbands. Need to remove the stigma of mental illness. Education will reduce occurrence. Marriage will be better without mental illness. Mental illness does not receive the same attention as physical health. Decency.
Strategies	Comparison. Acceptance and normalisation. Awareness of causes. Isolated females.
Possible subject positions	Female slaves. The faulty husband (emotionally defective). Everybody is sick. ? Neglected children (? bad parents).
Possible discourses	Population health. Gender typical roles. Emotional education. Child neglect. Feminist.

Analysis began with a focus on individual texts, as with the above example. The next stage of analysis was looking for relations between texts, to identify the repetition of statements and discourse within (and later between) my time periods. Relations between where and how statements surfaced, the authority behind the statements, and how these could be categorised enabled the identification of discursive formations and 'broader' discourse. Clinical discourse, as an example, emerged through a variety of surfaces such as research, policy, media, and letters, authorised by medicine and psychiatry and persons using services, and categorised within notions of health and *wellbeing* from a Western scientific base.

As I became more comfortable identifying archaeological notions in text, my methods shifted to playing with text in different ways, such as through asking questions, (sometimes contained within Microsoft Excel work sheets). Thinking supported me to play with different ideas, as per the below example, to identify questions and assumptions, another snapshot of time during my analytical journey.

Table 2.

Playing with Text

Text	What is not being said?	What are the assumptions?	How it is being done?
Whānau Ora — an integrated whanau approach supporting seamless access to health and social services. Whānau Ora is an approach that puts whanau and families in control of the services they need, to work together, build on their strengths, and achieve their aspirations.	Family and whānau continue to experience difficulties accessing services they need (flawed/disjointed). Services are deficit focused and controlled by the service. A lack of partnership with family or between families? leads to a lack of agency and aspirations.	Whānau Ora improves service access through 'integrated approaches'. Family has strengths and want control of services. They want partnership. They aspire. Questions – What are their aspirations? What does 'integrated' mean and who decides? How can family control service provision – what are the limitations and what resources would be needed?	e.g. Building-strengths: Pastoral power translating information to the family – from what discourses? Disciplinary techniques shaping conduct to be/become Whānau Ora (healthy family). What is a healthy family – one in control, responsible?

Genealogical analysis was the next 'layer' integrated by seeing what was being claimed as true, who was making the claims for what purposes, and how values and rules shaped practice. In the example in Table 2, Whānau Ora as a notion within policy was constructed by the government at the turn of the century to involve family in supporting Māori *wellbeing*. Several years later, ‘Whānau Ora’ emerged in documents as a strategy for *inequity* in health outcomes. Pastoral power enabled the transfer of knowledge from policy to practices, with disciplinary tactics shaping the conduct of family within practices. Analysis through a genealogical lens between the three different time periods analysed supported the identification of dominating discursive constructs, supporting certain things to be thinkable and sayable; for example, family as *carers* to then be integrated into policy as *partners* over the following decades. Genealogy also supported to identify what was missing; for example, the absence of family in early community care policy and guidelines. Further analysis occurred through writing up the sections within each of the chapters. The first (messy) drafts provided opportunities to note repetition of statements and discourse, possible relations with power, resistance, and subject construction. Rewriting the chapters enabled further analysis and better flow and coherence and providing more ‘text’ (my writing) for questioning and further analysis.

I perceived analysis of a specific time period to be finished according to the employment of my research questions by identifying discourses, and exploring the power relations between knowledge and the effects of subject construction. This did not mean that analysis was actually finished, as I, or another researcher, could continue to analyse the data and identify other themes or arguments. However, it is acceptable within a poststructural stance to view research as always incomplete, as there are no ‘final truths’ to uncover (Graham, 2011; Tamboukou, 1999).

Analysing Māori Text From an Ethical Stance

As introduced in the introductory chapter, and noted earlier in this chapter, analysing and writing on texts concerning or written by Māori was an ethical dilemma in my research. I was aware that from the position of a European white male, my experiences of privilege and socialisation from a white, male, European position in conjunction with using European philosophy as research methods were conditions for potential bias and injustice when analysing and writing text by or about Māori. I was aware that analysis from within my European gaze had the potential for further marginalisation and colonisation through my writing. Feedback and advice from occupational therapists who identified as tangata whenua was one strategy supporting me to check and reflect on my thoughts and writing; a form of ethical consultation. ‘Te Ara Tika, Guidelines for Māori research ethics: A framework for researchers and ethics committee members’, originally published in 2010 by the 'Health Research Council’ on behalf of the Pūtaiora Writing group, guided consideration of how my research might impact Māori and my obligations to te Tiriti o Waitangi.

Gaining an understanding of Māori cultural worldview, including notions such as mātauranga Māori, Māori frameworks, and the impact of colonisation, occurred through reading a number of tangata whenua and tangata Tiriti researchers and authors concerned with these topics. Delving into Māori-by-Māori authorship has significantly broadened my understandings of Māori cultural values and practices and the impact of colonisation, marginalisation, and racism. The following list is not exhaustive, rather, provides examples of some of the authors and researchers that shaped my understanding of Te Ao Māori including relations with colonisation. The conceptual framework 'Te Whare Tapa Whā', developed by Mason Durie (1985) provided significant influence within my exploration of wellbeing in Chapter Seven. 'Te Whare Tapa Whā' was also a good example for me on how ideas and concepts presented as 'new' are often developed from existing ideas. The Mason (1988) report and inquiry (1996) provided significant focus to Chapter Six, detailing examples of Te Ao Māori, including service provision, constrained within Western ways of doing.

Writing from Margaret Mutu (e.g., Mutu, 2018) provided insights into Māori rights and sovereignty under te Tiriti o Waitangi and the role and possibilities arising from Treaty claims. Hirini Moko Mead (2022), Te Ahukaramū Charles Royal (2012), and Damiel Hikuroa (2017) supported my basic understanding of mātauranga Māori as Māori identity through systems of knowledge. The website E-Tangata was a source of experiences and stories that personalised the impact of colonisation on Māori identity and self-determination. Researchers from tangata whenua identities, such as Jade Le Grice (2017), Lara Greaves (Greaves et al., 2021), Tracy Haitana (2022a, 2022b; Haitana et al., 2023), and Cameron Lacey (2022) provided alternative understandings of the research focus through Māori Kaupapa (ways of seeing and doing) on Western notions such as family and whānau relations, rights and *equity*. Finally, Heather Came (2013) provided insights on analysing and writing texts on Māori from the position of tangata Tiriti.

As noted by Cox et al. (2024), an ethical concern lies in the possibility of furthering marginalisation and colonisation through analysing Māori discourse or suppressing Indigenous knowledge through excluding Māori and choosing to focus on European texts and researchers. As my research developed, it was clear that I could not ignore inclusion of Māori texts, and from that position I have aimed to analyse and write in an ethical manner that upholds Te Tiriti o Waitangi. However, in acknowledging my stance and limitations through starting my journey in Te Ao Māori (worldview and cultural values and practices), I recognise that opportunities for deeper understanding is inherent within my research thesis.

Summary

In this chapter I have explicated the design of the study through detailing aspects of how the last two chapters (philosophical framework and methodology) informed the choice, gathering, and analysis of texts. The next three chapters provide analysis of the data, followed by the discussion chapter and limitations of my research.

Chapter Five: Community Care and the Problematic Family (1950–1979)

Introduction

The philosophical and methodological chapters of this thesis noted how the players involved in various iterations of *consultation*, including under the MHA, 1992, may be constructed as subjects and discursively shaped according to Foucault's notions of power/knowledge. The following three chapters aim to expose discourses and discursive conflict (Foucault, 1994g) concerning the emergence of iterations of *consultation* within three critical time periods from the 20th and 21st centuries.

The first two chapters of analysis concern the significant rupture in practices towards the mid and end periods of the 20th century. The first chapter points to the problematisation of institutional care and emerging discourses that made *community care* possible from the 1950s to the 1970s. Within this time period, my analysis identified informal 'iterations' (Foucault, 1984b) of *consultation* through shifting practices in mental health service provision enabling greater inclusion of family and whānau. The second chapter concerns the (re)-emergence of family responsibility for persons diagnosed as mentally ill from the mid-1980s to the turn of the century, including discourses that shaped the formal emergence of *consultation* as Section 7A within the MHA, 1992. The third chapter of analysis moves to the 21st century to analyse present day discourses concerning the repeal and replacement of the MHA, 1992, and consider how former discourses concerning the notions of *consultation* (identified in the first two chapters of analysis) circulate and influence contemporary practices concerning family and whānau participation and decision making within mental health law.

This first chapter of analysis focuses on the emerging discursive practices both limiting and enabling the greater visibility of mental illness within the community, and thus greater potential for family association and involvement. Mental health service provision in Aotearoa New Zealand was predominately delivered through large psychiatric hospitals run from the mid-1800s to the end of the 20th century by the government and health boards. Those diagnosed with a condition perceived as warranting incarceration became a ward of the State removing responsibility from the family. The late 1960s and early 1970s were dominated politically by social welfare policy and emerging human rights discourses for *patients* which endorsed planning a reduction of institutional accommodation. This signified a slow shift towards higher levels of assessment and interventions outside the hospital setting (Brunton, 2003; Department of Health, 1969; Joseph et al., 2009). Dominant practices included the promotion of mental health as a concept through a variety of strategies with increasing family and whānau involvement within evaluation and intervention practices.

My analysis of texts from the 1950s to the end of the 1970s identified discourses that problematised institutionalisation as a practice, opening space for the construct of community service provision. A 1953 report by the WHO provides a thread throughout the chapter, offering an illustration of relations between thought and actions (Rose, 1999). 'The Community Mental Hospital: Third Report of the Expert Committee on Mental Health' (WHO, 1953) is noted in this research as a significant text through promoting the provision of strategies to oversee and administer services targeting mental health (rather than a narrow focus on mental disorder), and promoting service provision in the community within member nations. The report is considered noteworthy in my research as strategies suggested in the report materialised in Aotearoa New Zealand in the following decades. Strategies included research on prevalence of illness, educating the general public on mental health, and providing services for the *mentally ill* as outpatients within the community. Family was not specifically identified as a strategy within the report, suggestive that discourses concerning family involvement were constructed as irrelevant during this period.

This chapter begins with an analysis of key discourses found in the 'The Community Mental Hospital' (WHO, 1953) signalling a relocation of psychiatry's gaze to encompass spaces outside of the institution which, when enacted in the following decades in Aotearoa New Zealand, enabled new relations between mental illness and family. The chapter continues by identifying discourses that supported the inclusion of family within practices during shifts towards *community care*. The chapter concludes through a discussion on the invisibility of the Western family as a taken-for-granted norm, and thereby the marginalisation of non-European people and families during this period.

The texts analysed to produce the findings for this chapter could be organised into four categories: texts that guide and regulate mental health assessment and treatment/practices (i.e., from WHO); Acts of law; research and media; and articles and letters appearing in publicly available publications that document experiences and practices concerning mental health practices in relations with family and whānau.

Notably absent in the texts available for analysis from this time was any formal policy documentation specifically concerning mental health service provision in the community. The research questions guided the choice of texts through either directly or indirectly signalling implications between mental health service practices and family, the potential for subject position generation, and possibilities for iterations of *consultation*. Texts analysed in this chapter and the following chapters appear in centre-alignment with a footnote and as a footnote if not directly quoted. Supporting scholarship is found as in-text citation, with the source information in the reference list at the end of the thesis.

Emerging Strategies of Identification, Education, and Community-Based Intervention

Setting the Scene

The problematisation of institutionalisation for managing mental illness materialised through research and practice changes in Western Europe and North America from the 1950s. This first decade post-World War II witnessed theoretical research questioning institutional practices, alongside developments in psychopharmacology providing possibilities for persons diagnosed with significant mental disorders to access treatment in the community (see Boek, 1957; Gronfein, 1985; Lemkau, 1958; Susser, 1958). The possibilities for shifting practices previously secluded within institutions into the community required consideration of potential societal responses. Active treatment rather than custody in psychiatric hospitals was promoted widely at an international psychiatric conference in 1953, summarised in a report titled ‘The Community Mental Hospital: Third Report of the Expert Committee on Mental Health’ (WHO, 1953). This report is noted in my research as authoritative text, as the report detailed practices that eventuated in Aotearoa New Zealand in the following decades.

The Problem of Public Education in the Move Toward Community Care

The establishment of services based in the community was noted as expert strategy to identify and reduce the prevalence of psychiatric disorders. Education to the general public was suggested to increase general understanding of mental illness as ubiquitous and existing on a continuum of severity, and the role of the psychiatric hospital in supporting the identification of cases that require treatment:

> The first type of information which needs to be spread concerns… the nature of psychiatric illness. It needs to be spread on both a professional and a popular

> plane, reaching other members of the medical profession, such as family doctors and specialists, and reaching the general public. In the past, the attempts to pass this information to the latter group have usually been made through mass propaganda methods, employing lectures, posters, radio talks, and public lectures. It is, however, becoming evident that such mass methods are less effective than the approach to small groups of key individuals in professions which influence popular opinion and understanding, such as public health nurses, teachers, community leaders, industrial supervisors, trade union officials, and ministers of religion.[9]

Circulating knowledge on the taboo subject of mental illness, contextual to its historical confinement, required strategies that translated the knowledge of mental illness into principles understood by the general public. Madness, and its construction into *mental illness* and *mental disorder* from the 18th century (Foucault, 1989), had previously been exiled from the community, hidden within asylums and psychiatric hospitals. Psychiatry from its founding days, as located in the treatises of Euro-centric physicians, such as Pinel[10] and Barlow[11], promoted segregation from the community to eliminate objects causing madness and disconnect persons from damaging influences that might delay a person's recovery. Through separation, public understanding of mental illness was diminished and the practices within the hospital were either unfamiliar or misunderstood; hence, the need for public education as identified by the WHO[12]. Concern by the WHO that psychiatric disorders in Western Europe and North America totalled at least 40% of hospital beds by the 1950s provoked deliberation on the nature and prevalence of mental illness, and approaches to reduce incidence.

Previous messaging, such as through public radio and posters, were thought inadequate means to educate the public, providing an opportunity for strategies involving 'trusted' health professionals to construct mental illness as a tolerable event within the community. However, there was concern that education on specific mental disorders might be detrimental through "the danger of creating within the community a

---

[9] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (pp. 6-7). Author.

[10] Pinel, P. (1806). *A treatise on insanity: In which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public* (Vol. 1806). W. Todd.

[11] Barlow, J. (1845). On man's power over himself to prevent or control insanity. *American Journal of Psychiatry*, *1*(4), 289-319. https://doi.org/10.1176/ajp.1.4.289

[12] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (pp. 6-7). Author.

hypochondriacal attitude on the subject of psychiatric disorders”[13] constraining ‘illness’ within education practices. A focus on mental health was suggested as preferable alongside identification of stress as a precipitating event occurring within different developmental life stages:

> Mental health education should preferably take the form of attempting to disseminate knowledge on the fostering of mental health rather than on the types of mental illness. Mental health education, therefore, is probably best focused on the psychological needs of different periods of development in the life of the human being and the different types of stresses characteristic of such situations as the home, the school, marriage, and work, so that understanding may be spread of the way in which these stresses may be diminished and the individual assisted to reach a satisfactory resolution of the various problems which inevitably face the human being in these situations.[14]

The convergence of discourse within the report represented a rupture in the understanding of mental illness and treatment. An intersection of biomedical and psychological discourses underpinned public health education on mental health. Using education as a key tactic to identify stress, public health nurses and teachers could operate within infancy and schooling; industrial supervisors and trade union officials with workers; community leaders and ministers of religion in social contexts and the latter years of life. The body was categorised into life stages for examination, enabling the circulation of psychiatric discourses throughout the general population. Public health nurses, in particular, were noted in the report by the WHO as beneficial through their ability to access homes and develop trust to witness intimate relationships. Practices of visiting the home, schools, workplaces, and other spaces to identify the presence of stress within and between the family became a focus on psychiatry in the community.

Moving away from more passive forms of education through “lectures, posters, radio talks, and public lectures”[15], the WHO constructed psychiatric knowledge to reveal and target persons deemed at risk of illness and, through association with stress, their family

---

[13] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (p. 7). Author.

[14] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (p. 7). Author.

[15] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (p. 7). Author.

members. A biomedical construction of the family supported the operation of pastoral power to translate psychiatric knowledge contextual to life events. A normalising gaze could be employed by the nurse as expert, promoting self-examination and behavioural changes to promote mental health and diminish psychological stress.

The Construction of Family Dynamics as Contributing to Mental Illness

Possibilities for disciplinary techniques for shaping conduct, and the development of subject positions for family members emerged in the context of the home as the remit of interest and expanded from the individual to the interactions between family members. As recommended by the WHO[16] the notion of health professionals as witness to the relationship between key life events within the family and mental health was normalised in Aotearoa New Zealand, evidenced in this newspaper article in the *Press* in 1965:

> The family doctor is often an intimate observer of the responses to marriage, to the growth of a family, to the departure of the grown children, and to the retirement of parents—all phases of life which produce anxieties and strain relationships and often overtax the mental resources of the individual.[17]

The problematisation of the family developmental life cycle through identification of relations between family conduct, life events, and the emergence of mental illness emerged post-World War II within psychoanalytical research (see Friedman & Friedman, 1970; Nuffield, 1954; Wolman, 1961; Wolman, 1965). Aetiology of significant mental disorders, such as schizophrenia, for example, encompassed the notion of harmful parenting. The concept of the *schizogenic mother*, as one example, popular in research in the 1950 and 60s, suggested that in some instances in response to conflict between mother and child, the mother's manipulation of the child's reality to meet her own needs precipitated the development of psychosis.[18] The combination of the words schizophrenia (schizo) and genes (genic) and mother, constructing relations between illness, genes, and parenting:

> Schizogenic families displayed more conflict, failure, and confusion during the interactional task than control families, and, fathers and mothers of schizophrenic offspring displayed more "anxiety and tension", "depressive

---

[16] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[17] Mental health. (1965, May 17). *Press*, p. 12.

[18] Mitchell, K. M. (1969). Social class and the schizophrenogenic mother concept. *Psychological Reports, 24*(2), 463-469. https://doi.org/10.2466/pr0.1969.24.2.46

> mood", "evasiveness" and "lack of interest" than fathers and mothers of normal families. Mothers of schizophrenic offspring were also described as more "hostile" than control mothers.[19]

From the above research findings, parents of persons diagnosed with schizophrenia were categorised by behaviours suggestive of neglect ("lack of interest") and anti-social behaviours ("hostility" and "conflict"). Possibilities for 'othering' family through categorisation against norms concerning family dynamics arose from the 1960s, with the formulation of psychological theories typically resulting from interviews, and observations of group therapy sessions within the hospital.[20] Bringing family into the space of the hospital to identify the causes of illness supported the construction of family as sick and in need of treatment itself. Promotion from the WHO[21] to provide a focus on mental health was offset through the diagnosis of family. Harmful relations between family members arising from such things as neglect and hostility supported the notion of the family unit *at-risk* and in need of protection.

In the 1970s, the 'Federation of New Zealand Societies for Protection of Home and Family', urged the government to provide an increase in the number of social workers trained in psychiatry to enter homes. Extending the function of medical services into schools, it was proposed that social workers could identify stress and behaviours believed to be harmful to mental health and provide alternative places to support the vulnerable. The following example was included in a newspaper article:

> "three boys aged 19, 16 and 14 whose father was an excessive drinker and who was introducing the oldest boy to similar ways. The mother was under great stress but would visit a psychiatrist only if a home was found for the youngest boy. A foster home was found but the boy's father took him home for lunch each day, thereby unsettling him. The foster parents gave the boy up because of his father's bad influence. The mother tried to file for a separation but the father talked her out of it. Such a child needed a decent home to go to," said the delegate.[22]

---

[19] Friedman, C. J., & Friedman, A. S. (1970). Characteristics of schizogenic families during a joint story-telling task. *Family Process, 9*(3), 333-353. https://doi.org/10.1111/j.1545-5300.1970.00333.x

[20] Mishler, E. G., & Waxler, N. E. (1965). Family interaction processes and schizophrenia: A review of current theories. *Merrill-Palmer Quarterly of Behavior and Development, 11*(4), 269-315. 0

[21] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[22] Homes sought for adolescents. (1970, October 8). *Press,* p. 6.

Mental illness was credited by the Federation as breaking marriages and homes, promoting a gaze on family in relations against the notion of decency. Relations between mental illness and the notion of decency surfaced to suggest that homes, and thus family members, needed protection from indecent behaviour. Previously, practices enabled those perceived as sick removed from the family and placed into the institution of the psychiatric hospital. It was now possible to remove the vulnerable from the sick to be placed in a 'safe' environment. Removal of children deemed *at-risk* into foster care or hostels was one potential practice sanctioned by the State.

Hostels for adolescents within the community as a solution, rather than placing them with relations or whānau, emphasised State responses towards societal issues, valuing social welfare practices dominant in Aotearoa New Zealand from the 1950s to the end of the 1970s.[23] The Federation differentiated hostels from institutions by noting that they were 'well run' and preferable, as institutions were used for those unable to access the hostels due to wait lists. Thus, hostels were promoted as a 'new' practice.

Foster homes, as an alternative strategy for children removed from the biological family, also had possibilities to impact the health of the foster family. In a letter to the popular magazine *Women's Weekly* in 1975, a foster mother recounted her "bitter experiences" condemning assumptions from a previous reader's letter that the aims of fostering were financially driven:

> Certainly, some foster homes are neglectful but there are many fine people who love and cherish these kids and do their upmost for them, expecting nothing in return. My husband and I took two little sisters and went without to give them a good education. We followed them through the darkest experiences of drugs, mental hospitals, rebellion, hatred, lies and degradation. We stuck with them, and one made the grade… she is now married with two beautiful children. The second chose to go back to the life she had left, and my husband ended up with a nervous breakdown. The last three years of our retirement have been hell.[24]

The letter continued that mental illness born from "selfish parents" did not discriminate against "fine people". Mental illness was credited with moving in all social circles, no longer confined to troubled homes. It could counteract education, values, and morals. It

---

[23] Department of Health. (1974). *A health service for New Zealand: Presented to the House of Representatives by Leave*. Author.

[24] Parents who are underpaid. (1975, June 23). *Women's Weekly*, p. 38.

could form relations with drugs and anti-social behaviours. It was inherent within the biological family and could be acquired without a biological link. Other versions of family, such as the foster family, were not exempt from experiencing mental illness through non-biological intimate relations. Removal from the source to break the cycle of mental illness had the potential instead to extend its reach, reproducing illness in early iterations of *community care*.

The Production of Mental Illness as a Norm

The reach of mental illness was noted in the newspaper, the *Press*, as a statistical possibility for one in five persons to acquire it.[25] Circulating notions of illness prevalence through statistics supported the concept that anyone was potentially susceptible regardless of their background or upbringing. Public health discourses circulating in texts that guided and regulated practices constructed a form of mental illness existing within the community, and one which did not necessarily relate to the psychiatric hospital. By 1972, the WHO noted mental illness as "prevalent" within the community, and promoted the identification of its sources and the standardisation of its forms.[26]

The WHO[27] provided authority of the 'truth' of mental illness as a societal issue, a problem no longer contained within the psychiatric hospital. They noted relations between the functioning of society and the production of mental illness that required signposting; the institution of marriage and the performance of families was increasingly noted as troubling in the news. Newspaper articles circulated knowledge concerning the destructive nature of intimate relations, where "emotionally defective husbands" made "slaves" from wives[28], and "emotional cannibals" impacting friends and partners.[29] Family and community was breaking down from the "tensions and anxieties" inherent within mental illness.[30] Mental illness was constructed as a universal yet ambiguous construct that could surface within any intimate relations within the community.

---

[25] One in five mentally ill. (1971, March 31). *Press*, p. 2.

[26] World Health Organization & Candau, M. G. (1972). *The work of WHO, 1971: Annual report of the Director-General to the World Health Assembly and to the United Nations*. Author.

[27] World Health Organization & Candau, M. G. (1972). *The work of WHO, 1971: Annual report of the Director-General to the World Health Assembly and to the United Nations.* Author.

[28] One in five mentally ill. (1971, March 31). *Press*, p. 2.

[29] Christmas message. (1971, December 21). *Press*, p. 14.

[30] Mental health. (1965, May 17). *Press*, p. 12.

Through the knowledge that illness could no longer be contained in the hospital, sites within the community for treatment options, as suggested by the WHO[31] further shifted practices concerning mental illness into formalised spaces within the community. A place for psychiatry outside the walls of the larger psychiatric hospital was needed for psychiatry to function. The birth of the psychiatric day hospital became a new space that could meet with *patients* and their families. Involving family was noted a necessity, regardless of their role in illness causation or not, to address family expectations and support the 'unwell' person to function in the environment where they spent the majority of time.[32] A family approach as an intervention strategy emerged to offer support and began to problematise the notion of responsibility that would emerge in greater force within the next decades.

Section Summary

This section noted how intersection between public health, biomedical, and psychological discourses made mental illness thinkable as a phenomenon within the community. Mental health and stress were constructed as objects to enable educational strategies to identify precipitators of illness and thereby reduce prevalence. Biomedical and psychological research ascertained the family as a site for the emergence of stress and illness, and legitimised health professionals to enter homes and consider the family developmental life cycle within interventions. The notion that family generated mental illness through genetics and behaviours enabled possibilities for the break-up of family units that were constructed as *indecent*, and thus inappropriate to raise children. By the 1970s, public health discourses surfaced in the media highlighting the presence of mental illness in the community as a common phenomenon. Knowledge of mental illness in the community provided possibilities to construct family as deviant through association with illness development, a popular notion within the emerging decades of *community care*.

Mental Health is a Family Affair

The above section analysed how through possibilities to educate the general public, family members emerged as possible precipitators to the generation of illness through

---

[31] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[32] Bennett, D., Fox, C., Jowell, T., & Skynner, A. R. (1976). Towards a family approach in a psychiatric day hospital. *British Journal of Psychiatry, 129*(1), 73-81. https://doi.org/10.1192/bjp.129.1.73

stress. This section analyses in more depth the conditions circulating family as problematic; thus, also enabling the inclusion of family in interventions.

Inclusion of Family in Psychiatric Treatment Through the Mechanism of Rehabilitation

Although the WHO[33] noted mass propaganda methods as less effective than trustworthy professionals, reaching out to the masses through popular media sources remained a tactic to circulate emerging service responses to mental illness. In an article titled "Individual treatment is not the ideal at Calvary clinic where…mental health is a family affair", *Women's Weekly* magazine introduced the day hospital/outpatient clinic and the concept of the rehabilitation programme. The article, noteworthy for its focus on mental health and its complete absence of the term 'mental illness', identified emotional stress as the object of concern within the family. A friendlier model of treatment in a "hotel like" environment welcomed the individual and their family for treatments:

> "People are becoming more aware of emotional problems and will seek help earlier" said Sister Oliver, who is tall, slim and quiet, with kind, understanding eyes. "With day hospitals opening up, people are more willing to accept help. What they have here is like any other outpatients department. There are no locked doors. We can have very distressed people here. Our ways of helping can form a relationship with a person after 24 or 48 hours. We try to help people in the family unit more than as individuals. If a husband accompanied his wife, who was in emotional stress, he would probably have to be included in her rehabilitation programme. In a similar way, we prefer to include parents of a distressed younger person. The person who comes here is not always the sickest person. The more sensitive one could break down, but may not always be the sickest."[34]

Encouraging the inclusion of family members within the rehabilitation process reproduced the concept that emotional stress was generated and could also be reduced from within intimate relationships. Relations between social and psychological health provided opportunities for interventions beyond the person seeking treatment. However, biomedical discourse continued to dominate through the notion of 'sick bodies' (the *patient* and family members – see discussion in the next section) interacting with each

---

[33] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[34] Mental health is a family affair. (1975, January 27). *Women's Weekly*, pp. 14-15.

other. The premise that the person seeking help was not necessarily the sickest, indicated the objects of mental illness and mental distress as visible and non-visible entities within individuals. The article, within a magazine for women, depicted women, visually and metaphorically, at the centre, engaging with female therapists (see Fig. 1), signalling that those (women) accepting help were more susceptible to the influence of stress and illness. This notion was also taken up in a speech by the medical superintendent of Kingseat hospital in 1971 for the Northland Association for Mental Health:

> The New Zealand wife was in a state of slavery," Dr. McDonald said. "All she gets is work without reward, stuck out there in suburbs. There are four times as many mothers attending my out-patients department as any other type of patient… "Most New Zealand men are emotionally defective, but it is because the husband just doesn't realise what he is doing".[35]

Figure 1.

Calvary Clinic

Female isolation surfacing through geographical and emotional confines in marriage was noted by the medical superintendent to intersect with stress and ill health. A feminist discourse emerged through the notions of work unacknowledged within gender-typical roles. The above quote represents the mother in the family in a position of 'slavery', indicating oppression and subordination as antecedent to the generation of stress. The faulty husband, represented as the cause of stress, and who lacks insight into

---

[35] One in five mentally ill. (1971, March 31). *Press*, p. 2.

his own behaviours, indicated the need for education; hence, inclusion within treatment. As mental health services shifted into the community, psychiatry shifted into the home, so that potentially everyone could be sick and, therefore, in need of treatment.

Services, such as the rehabilitation unit, with its carpeted home-like hallways, welcomed and endorsed help-seeking from women, and the potential ‘perpetrators’, to search out and identify the presence and function of stress within intimate relations.[36] The physical environment, representing the family home, blurred the roles of *patient* and family member; yet, medications and shock treatments, available at the Calvary clinic, provided a space for traditional psychiatry, communicating and legitimising the unit through association with medicine. The absence of locked doors promoted notions of autonomy and responsibility to attend, curtailing the *patient* subject and diminishing psychiatry’s role as a sovereign power in forcibly moving bodies through greater emphasis on personal responsibility. The emphasis on voluntary therapeutic treatments, such as crafts, table tennis, and yoga, provided opportunities for self-care through training and the development of strategies to manage stress (Foucault, 1994i). The gaze of psychiatry hid behind “kind, understanding eyes”[37] concealed itself within the yoga class and the friendly conversations between therapist, *patient*, and spouse.

The home-like environment encouraged natural and desired conduct: to diminish emotional stress arising from marital and parental disharmony, the stress of child rearing, or the restricted suburban lifestyle. The home-like qualities of the clinic could be replicated in the home, comparisons could be drawn, and practices could be copied. The diminished presence of psychiatry as a sovereign form of power (though still present through ‘shock treatments’) highlighted ‘old’ ways of doing things to encourage new ways to manage health, not illness.[38] New practices, constructed as progressive, supported the legitimisation of practice changes. Self-care practices, such as yoga, and practices encouraging connection, such as table tennis, continued the focus on mental health with a less visible presence of mental illness in the background.

Conditions of Possibility for Productive Involvement of Family

Consultation as a formal practice, attached to law, had yet to materialise. Instead, as identified above, a variety of practices of ‘inclusion’ of family members emerged at this

---

[36] Mental health is a family affair. (1975, January 27). *Women’s Weekly*, pp. 14-15.

[37] Mental health is a family affair. (1975, January 27). *Women’s Weekly*, pp. 14-15

[38] Mental health is a family affair. (1975, January 27). *Women’s Weekly*, pp. 14-15.

time within the psychiatric hospital, the outpatient's clinic, and within the home. This can be understood analytically as providing the conditions of possibility for other forms of involvement to emerge.

A broadened approach to the 'internal fault' of the body constructed by psychiatric discourse provided the possibility of a shift to include family. Inclusion of family curtailed the concept of an individual internal fault by identifying that illness had the potential to reside in associated bodies, such as the *schizogenic mother* (popular theory in the 1950s), enabling the thinking and practice to include family but in more subtle ways. The 'internal fault' in the body became the internal fault in systems of bodies. A less intrusive psychiatric gaze encouraged the family to confess, through self-examination (Foucault, 1994h), the presence of stress, to identify their involvement in the development of illness or their own sickness, and their roles as possible victims and perpetrators. Confession provided possibilities for self-examination and to take on responsibility regarding the production and maintenance of illness within the family.

Inclusion of 'others' as ill provided the conditions for a psychiatric gaze to observe and question the family to discover their role in the development of their family member's illness and, if present, their own illness. This gaze provided opportunities for a productive role for family members through disciplinary mechanism to shape their conduct, lessening behaviours causing distress and illness. Inclusion of family also provided the conditions for the expansion of *community care* in later decades, since psychopharmacological developments for persons considered significantly unwell (Gronfein, 1985) afforded alternatives to hospitalisation. *Community care* also countered the restructuring of health systems in the 1970s arising from funding and management concerns (Joseph & Kearns, 1996) by questioning the need for segregation if mental illness was already at liberty within the community. However, the increasing presence of psychiatric discourse within the community was also contested.

Critique arose from several sources; from those within the profession, those receiving services, and those witnessing. Mistrust of psychiatry's concept of the faulty individual emerged in the 1960s and 1970s from within the profession, through the anti-psychiatry movement (discussed later in this chapter) (Berlim et al., 2003; McLaughlin, 2003). Accounts of abuses of power arose through the voices of those experiencing incarceration, broadly termed as the *service user movement* (discussed in Chapter Seven) (Adame & Knudson, 2007; Crossley, 2002). Mistrust of psychiatry and psychological interventions also surfaced through literature and film, such as critique of psychiatric power in ‘One flew over the cuckoo’s nest’[39] and ‘A clockwork orange’[40] (depicting a coercive, experimentalist, and self-entitled profession).

Section Summary

This section noted how discourses concerning gender in relations with marriage and role identity intersected with mental health, stress, and the formation of symptoms leading to a diagnosis of mental illness. Expansion of the faulty body into systems of faulty bodies continued a biomedical approach to treatment and provided the conditions to include family members in treatment. Education continued to be a strategy to promote the concept of mental health in settings that resembled the family home, and the outpatients clinic was constructed as a progressive site for treatment through the concept of rehabilitation. The clinics’ links to historical psychiatric treatments, such as shock treatments, supported the legitimisation of ‘new’ practices comprising self-care and family inclusive treatments. Discourses questioning the concept of the internal fault and practices associated with incarceration became prominent in the 1960s and 1970s (discussed further below).

From Hospital to the Community

The above sections analysed discourses concerning the identification of mental illness in the community and, ultimately, within the family unit, in part to reduce the prevalence of hospital admission through identification and intervention on the stressors related to illness development. ‘The Community Mental Hospital: Third Report of the Expert Committee on Mental Health’ also noted that “The first type of information which needs to be spread concerns the activities of the hospital itself”.[41] This section analyses a brief period at the start of the 1970s when psychiatric hospitals were opened to the public and television makers to make visible the types of people staying in the hospital and the types of interventions that they might receive. Opening the doors to the hospital also provided alternative possibilities to construct the family as a problem.

The Construction of the Hospital as a Safe but Temporary Space

In Christchurch, the television crew that produced the programme “Survey”, was based for 3-weeks in Sunnyside psychiatric hospital, a large psychiatric hospital operating

---

[39] Forman. M. (Director). (1975). *One flew over the cuckoo’s nest.* [Film].

[40] Kubrick, S. (Director). (1971). *A clockwork orange*. [Film].

[41] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (p. 6). Author.

from 1863 to 1999. The following paragraph on the programme from a newspaper article, included an interview with a woman who had developed an illness and was admitted into hospital:

> "This is my dream … that I can be like everybody else. I envy the office girls trotting round town and buying things in their lunch hour". The girl talking is 21, attractive and intelligent. But she has been unable to hold down a job for more than a few weeks. She has been so depressed that she has tried to kill herself. Listening to her is a woman who has experienced the effects of deep loneliness, to the extent that she has developed a phobia about going outside. For three years she never left her house. Her husband and daughters had to cope with a woman who had become mentally sick.[42]

The depiction of a young woman dreaming of engaging in common everyday activities, such as shopping during the lunch break, generated relations between good mental health and productivity. Productivity and consumerism were depicted as healthy norms in comparison to isolation, its resulting lack of productivity, and the detrimental impacts on the family unit. Isolation through hospitalisation could be justified through discourses of *risk*, but it had a temporary quality, as the presence of family suggested a previous time of health and productivity. *Risks* emerged through 'dangers to the self' and the *burden of care* legitimising hospitalisation but, as noted in the above text, treatments offered opportunities for a return to the family unit; the article depicted the *girl* as normal through her attractiveness, intelligence, and dream to be like everybody else. These conditions provided an acceptability for her and, more importantly, others in hospital to return to the community. The illness, as a temporary, external object to the body, enabled possibilities for its removal. A tension arose between the concept of the 'faulty body' and a healthy body invaded by mental illness as an external entity within psychiatry. It provided a schism within the body enabling the conditions for treatment versus incarceration and a possible return to the community.

"Survey" highlighted changes to the *patient* and to the hospital, as a modern place that could quickly heal someone in weeks, detaching itself from its historical powers of long-term incarceration:

---

[42] Mental health is next for "survey". (1970, August 21). *Press,* p. 3.

> There have been big changes at the hospital in recent years. In place of its purely custodial role it now provides intensive treatment. Most of the patients are there a matter of weeks only.[43]

The television crew spoke of a newer, safer, site of treatment, through their presence in the hospital. They permitted the interviewed woman to confess the anguish from loneliness through segregation and asked for societal acceptance that people experiencing mental illness could be like everyone else: a productive family member. A normalising strategy was used by the television programme and psychiatry: it aimed to minimise differences and seek similarities. It normalised through informing that "one in ten children"[44] will experience a breakdown and require treatment in a mental facility. It sought similarities through the image of an *office girl* "trotting around town in her lunch break".[45] It dispelled the need for incarceration as the illness itself had confined the woman in her own home for 3-years; she was safe to be back in the community after a short period of treatment.

She was also safe to come to the hospital, as "Survey" could testify. Observation, as a strategy to reduce myths about the activities of the hospital, educated the public to support the normalisation of brief hospital admission and thereby *community care* approaches.[46,47] However, "many people entertained "weird fantasies" about mental institutions"[48] according to the medical superintendent of Kingseat Hospital. Further access was needed into the hospital to go beyond the passive participation of the television screen to observe that which had been hidden. Discourses that presented mental illness as bizarre, peculiar, and dangerous, popularised through cinematic movies, such as 'Psycho'[49], 'Repulsion'[50], and 'Asylum'[51], required countering.

The open day of Kingseat psychiatric hospital, Auckland, in the autumn of 1971, was one such event that welcomed 400 visitors to dispel their "fantasies". Overtly watching people receiving treatment also enabled subsequent covert observation of clinicians

---

[43] Mental health is next for "survey". (1970, August 21). *Press,* p. 3.

[44] Hospital opened to public. (1971, May 7). *Press,* p. 10.

[45] Mental health is next for "survey". (1970, August 21). *Press,* p. 3.

[46] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[47] Department of Health. (1974). *A health service for New Zealand: Presented to the House of Representatives by Leave*. Author.

[48] Hospital opened to public. (1971, May 7). *Press,* p. 10.

[49] Hitchcock, A. (Director). (1960). *Psycho*. [Film].

[50] Polanski, R. (Director). (1965). *Repulsion.* [Film].

[51] Ward Maker, R. (Director). (1972). *Asylum*. [Film].

through a brief panoptic gaze from the visitor. A relation of surveillance enabling a normalising judgment (Foucault, 1977) onto the hospital as a place of healing, not torture and abuse. The function of disciplinary actions shaping the body to remove mental illness, shaped the clinician through their visibility and circulated the ‘truth’ of this new space. The public experienced that the mentally ill were safe, and that staff were kind and understanding[52] as they facilitated the journey back to normality. Normalising discourses promoting hospital admission as safe and acceptable for those receiving treatment constructed a safe place for family to also enter. The safety of the space of the hospital and similar spaces in the community, such as outpatient departments, provided conditions for family involvement and opportunities to counter unhelpful discourses, such as those arising from societal and familial stigma about mental illness.

The Construction of Family as Stigmatising

> We hope, by opening all our doors today, to help break down some of the prejudices and stigma attached to mental illness… many people had come out of curiosity and others “perhaps because they are on the verge of a nervous breakdown”. Yet others had relatives or friends who, at one time or another, had been patients at Kingseat.[53]

In the previous sections of this chapter, family were depicted as problematic, as a site for the emergence of mental illness through causative behaviours, such as bad parenting, and through their own sickness. In the above quote, family was correlated with stigma and prejudice, enabling new possibilities for their inclusion in psychiatric practices. With shorter admission times, family materialised as more likely to become involved with their relatives, who may have previously experienced hospitalisation for years. New possibilities of inclusion emerged for family that were not sick or antisocial, rather, lacked the appropriate approaches towards mental illness to support possibilities for *community care*: “We hope that by bringing mental illness from behind the locked doors it will help remove some of the old attitudes about the subject”.[54] Tensions between discourses promoting mental illness as normal but people with mental illness as abnormal could be addressed through attending to stigma. Possibilities for family to be a positive force began to materialise as different from more negative constructions.

---

[52] Mental health is a family affair. (1975, January 27). *Women’s Weekly*, pp. 14-15.

[53] Hospital opened to public. (1971, May 7). *Press*, p. 10.

[54] Mental health is next for “survey”. (1970, August 21). *Press*, p. 3.

Family reunification was possible if the family unit changed their attitudes enabling *community care* to succeed.

Section Summary

This section identified that with shorter admission times, conditions for greater family involvement began to materialise, providing the conditions for *consultation* to materialise through the clinician-family relationship. To support the concept of *community care* in relation with short hospital admissions, psychiatry identified stigma and prejudice within the community and family as constraints. Strategies to promote mental illness in the community and increase family involvement included ‘opening the doors’ of the hospital for television cameras and visitors. Discursive relations between *risks*, mental health, and productivity, normalised a need for short hospital admission and reintegration back into the community; thus, the notion of long-term incarceration shifted towards an inviolable practice limited by ‘old’ attitudes. The notion of incarceration as an abuse of human rights also emerged to strengthen the acceptability of *community care*, as discussed in the section on ‘rights’ below.

Mental Illness as a Social Event

The previous section identified the construction of the hospital as a safe space for treatment with short term admissions. Insight into the workings of the hospital through television and visits by the general public, including family, aimed to normalise mental illness and those experiencing it from the perspective of psychiatric discourse. This section identifies an alternative view of mental illness that emerged in the 1960s, critiquing psychiatry as an agent of social control and mental illness as a social event.

The Construction of Psychiatry as Social Control

Discourses promoting the notion of community care through critique of institutionalisation and its characteristics of abuse and control emerged in the 1960s and 1970s, by a group loosely titled the *anti-psychiatry movement*. ‘Members’, including David Cooper, Franco Basaglia, Thomas Szasz, R. D. Laing, Erving Goffman, and Michel Foucault, aimed to reform psychiatric practices by highlighting the abuse of human rights; thus, critiquing the embedded power dynamics of the profession (Berlim et al., 2003; Crossley, 2006). According to the ‘movement’, power relations within psychiatric institutions and the medicalisation of mental illness enabled objectification, stigmatisation, and social control. [55,56,57,58] In an opinion article from the Victoria University of Wellington Law Review, Dolan mirrored concerns raised in the northern hemisphere:

> The diagnosis of insanity is a statement about the person's social performance, rather than about his biomechanical or physiological functioning. Commitment is a political act requiring power and coercion. It functions to remove "undesirables" from society, not to cure illness.[59]

Discourses intersecting mental illness and the socio-political through notions of power and control enabled further normalisation of mental illness as belonging within the community. Statements pertaining to the oppressive nature of psychiatry, the abuse of liberty, and the management of perceived deviancy questioned not only the act of commitment but the legitimacy of the notion of mental illness as an internal defect. The profession of psychiatry had, through its conception, developed the notion of madness as an internal brain/body systems fault. Treatises on madness written by early physicians, such as Pinel[60], Haslam[61], and Esquirol,[62] drew from 'Enlightenment' principles from 18th and 19th century Europe that defined man as autonomous, a shift from earlier religious-centric explanations of behaviour (Cooper & Burrell, 1988; Foucault, 1984e). The autonomous human subject represented rationality through productive and social enhancing behaviours (Burkitt, 2002; Miller & Rose, 1995). Social deviance, therefore, indicated a lack of rational reasoning, defined by early physicians as deficient character, a lack of morality, excessive imagination, and unregulated passions and temper, all originating from within.[63,64]

---

[55] Foucault, M. (2011). *Madness: The invention of an idea*. Harper Perennial Modern Thought.

[56] Goffman, E. (1968). *Asylums: Essays on the social situation of mental patients and other inmates*. Aldine Transaction.

[57] Laing, R. D. (1964). Is schizophrenia a disease? *International Journal of Social Psychiatry, 10*(3), 184-193. https://doi.org/10.1177/002076406401000304

[58] Szasz, T. S. (1967). The psychiatrist as double agent. *Society, 4*(10), 17-24. https://doi.org/10.1007/BF03180072

[59] Dolan, N. E. (1973). Madness and the law. *Victoria University of Wellington Law Review, 20*, p. 383.

[60] Pinel, P. (1806). *A treatise on insanity: In which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public* (Vol. 1806). W. Todd.

[61] Haslam, J. (1809). *Observations on madness and melancholy: Including practical remarks on those diseases, together with cases, and an account of the morbid appearances on dissection*. J. Callow.

[62] Esquirol, E. (1845). *Mental maladies; A treatise on insanity*. Lea and Blanchard.

[63] Barlow, J. (1845). On man's power over himself to prevent or control insanity. *American Journal of Psychiatry*, *1*(4), 289-319. http://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.1.4.289

[64] Pinel, P. (1806). *A treatise on insanity: In which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public* (Vol. 1806). W. Todd.

Although upbringing and environmental factors were acknowledged, madness as an internal defect gained credence by psychiatry's alignment with medicine throughout the 19th century, notably through empirical research qualifying the development of classification systems and diagnosis (Engstrom & Weber, 2005; Jablensky, 2007). Psychiatry dedicated its gaze with a biomedical focus upon the body up until the 1970s. The biopsychosocial model developed by Engel[65] was, in part, a product of discourses critiquing emphasis on the internal fault, as the model broadened the gaze of psychiatry through acknowledging the unique circumstances of each *patient* (Borrell-Carrió et al., 2004). The unique circumstances of each person would necessitate the inclusion of their social contexts, as identified through earlier research indicating 'bad' parenting and genetic predisposition (see previous analyses in this chapter). Thus, the biopsychosocial model could formally incorporate the family within an intersection of the biological, psychological, and social in the diagnosis of mental illness.

The Construction of Family as Unreliable but Needed

As noted above, psychiatry, from its founding days, promoted segregation from the community to reduce the precipitators of illness, such as vices and bad influences.[66,67] Segregation enabled the construction of a diagnostic case through observation, external to social contexts, bar initial information from relatives or others. However, an uneasy tension arose from the introduction of the biopsychosocial model, which enabled diagnosis to include the elements of the psychological and social environment. Diagnosis intersected the faulty individual and their psychological responses to their environments which, by default, included family members through presence and absence. Diagnosis could then become a statement about social performance (rather than purely an internal defect), requiring observation in its natural setting, a difficulty for clinicians, as noted by Dolan:

> the doctor will rarely observe the patient in his normal social context over any length of time. Any strange behaviour will accordingly be interpreted as evidence of insanity. The doctor will have to rely to a great extent on the

---

[65] Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136. https://doi.org/10.1521/pdps.2012.40.3.377

[66] Barlow, J. (1845). On man's power over himself to prevent or control insanity. *American Journal of Psychiatry, 1*(4), 289-319. http://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.1.4.289

[67] Pinel, P. (1806). *A treatise on insanity: In which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public* (Vol. 1806). W. Todd.

> observations made by the family, yet, as Laing has demonstrated, the family is frequently the source of the trouble.[68]

Quoting R. D. Laing, a Scottish psychiatrist associated with the anti-psychiatry movement who correlated diagnosis of schizophrenia as a social event, Dolan reiterated mental illness diagnosis as a fabrication of rational responses to inappropriate family behaviour:

> the so-called “psychotic” symptoms of schizophrenics are perfectly rational when interpreted in their family contexts. The symptoms are elements of rebellion against tyrannical or bizarre parents, that is: they are rational responses to crazy situations.[69]

For the doctor to see the ‘truth’ of mental illness through the *patients*’ normal social context, a position for family as a tool for observation was needed. However, family, positioned as the cause of illness through their “tyrannical or bizarre” behaviours, generated a diffraction within discourses of family inclusion. Information from family was needed to understand the situation; however, the information could not necessarily be trusted. Dual relations of observation occurred as family examined the *patient* on behalf of the doctor, and the doctor examined the family through observation and their (and the *patient’s*) confession. The family, constructed as an unreliable but nevertheless necessary source of information, shaped an emerging partnership between clinician and family, furthering possibilities and limitations on the formation of *consultation* in the next decade. However, mistrust of family continued to constrain their participation throughout the 1970s notable through their general absence from law. The MHA, 1969, an Act that encompassed elements of *community care* within legislation through social welfare and peer-run organisations, made minimal reference to family, as discussed below.

Section Summary

This section identified that anti-psychiatry discourses questioning the practices of incarceration and the notion of a purely biological illness also supported discourses of the problematic family. Family, as implicated in the formation of illness, sustained anti-psychiatry notions that mental illness was a rational response to ‘bad’ parenting, for example, and, therefore, diagnosis reflected social performance not illness. The

---

[68] Dolan, N. E. (1973). Madness and the law. *Victoria University of Wellington Law Review, 20,* p. 388.

[69] Dolan, N. E. (1973). Madness and the law. *Victoria University of Wellington Law Review, 20,* p. 379.

emergence of the biopsychosocial model provided possibilities for a person's social context and psychological responses to be considered, sustaining anti-psychiatry notions of mental illness as a rational response to adverse environments. With the shift towards *community care*, reliance on the family to report on their family member to clinicians, enabled possibilities for engagement and future iterations of *consultation*. However, the information provided to clinicians was constructed as untrustworthy, including from an anti-psychiatry gaze, justifying their observations and confessions to be examined by the clinician in identifying the precipitators of illness, constructing potential boundaries for future *consultation* practices.

A Question of Rights

The previous sections identified family as a requisite to support the observation and assessment of *patients* living in the community. However, family involvement was limited and constrained by a lack of trust from clinicians, influenced through discourses such as stigma and poor parenting. This section analyses opportunities for family involvement in mental health Act practices, identified as generating future possibilities for the emergence of *consultation*. Notions of responsibility and self-reliance, dominant in the next period of analysis (Chapter Six) emerged within the shift of services to *community care,* though through relations with community organisations and peers. The notion of vulnerability for persons discharged from hospital, as noted below, highlighted the absence of family and an opportunity for countering a lack of rights through their involvement.

Hospital Care Reformulated as Elective With Possibilities for Family Agency

The implementation of the MHA, 1969, was touted to reduce barriers and support access to psychiatric care in a newspaper article: "The Act…removes all unnecessary formalities and bars to patients seeking treatment in psychiatric hospitals".[70] Under Section 15(1) of the MHA, 1969, the medical superintendent of a hospital had options to:

> (a) Treat that person without admitting him to the hospital; or
>
> (b) Admit him to the hospital for treatment without any reception order or request that would render him liable to be detained under this Act; or

---

[70] Psychiatric admissions changed. (1970 April 1). *Press, p.6.*

> (c) Permit him to remain in the hospital for treatment after he has ceased to be liable to be detained in the hospital.[71]

Treatment without hospital admission provided opportunities for the expansion of *community care* for persons requiring assessment under the MHA, 1969 through greater choice of actions for the clinician. Arrangements for assessment and treatment without committal, (noted in a newspaper article as "advantageous" to the *patient* and their family), and alongside possibilities of choice, constructed the notion of 'new' practices.[72] The concept of benefitting from treatment, congruent with the concept of mental health, supported *community care* discourse through notions such as autonomy and freedom to choose services in the community rather than experience commitment and institutionalisation. The notion of family benefitting if admission could be avoided, promoted *community care*, and possibilities for greater involvement of family. Possibilities for family to be involved in discharge processes, noted in the MHA, 1969 under Section 74(6), materialised through positions of care, oversight, and control:

> In determining pursuant to this section whether the state of mind of any person requires that he should be detained or treated as a mentally disordered person for his own good or in the public interest, the Judge may take into consideration the fact that some relative or friend of that person is able and willing to exercise sufficient oversight, care, or control of him, and may, as a condition of making an order for his discharge, require an undertaking in writing from that relative or friend to exercise such oversight, care, or control of the person so discharged for such time and in such manner as the Judge requires and as are set out in the undertaking.[73]

Early iterations of family involvement, in this case as an opportunity to provide information that could be considered in the decision making of discharge, reinforced the notion of family providing oversight and management of the relative; positions of responsibility through containment. This practice can be found dating back to the first Act in Aotearoa New Zealand; the Lunatics Act of 1846 which provided a similar function under Section 2:

---

[71] The Mental Health Act, 1969.

[72] Psychiatric admissions changed. (1970 April 1). *Press*.

[73] The Mental Health Act, 1969.

> Every such person while in such custody as aforesaid shall have the liberty of seeing his or her friends and legal advisers at all reasonable times; and nothing herein contained shall prevent any relative or friend from taking such insane person or dangerous idiot under his own care and protection, provided he enter into sufficient recognizance for the peaceable behaviour or safe custody of such dangerous lunatic or idiot.[74]

Inclusion of Section 74(6) of the MHA, 1969 and Section 2 of the Lunatics Act 1846 are examples where family could provide an agreement for the safe containment of their relative to discuss the situation with, at those times, Justices of the Peace and the Courts of Sessions, and the Judge, respectively. In both Acts, formal dialogue remained between family and the law, and communication between the family and clinicians was absent from these Acts.

The MHA, 1969 enabled deinstitutionalisation practices of containment of specific diagnostic populations, referring to "householders" as a term for those taking charge of and containing those persons leaving the hospital. The "householder" represented persons classified as "single patients" under Section 38(3) of the MHA, 1969, which enabled persons to be detained under the Act but placed "in the house of a householder" within a community setting, as opposed to hospital admission:

> Before making any such reception order the Magistrate shall examine the householder, and shall satisfy himself, by such means as he thinks fit, that the householder is a proper person to have the charge of the person so to be received, and that his house and its surroundings are suitable for the reception and detention of that person.[75]

Without defining the householder beyond occupier of the house, the Act stipulated a relation between formal processes of examination on the detained person and the householder to locate persons based on classification systems within defined enclosures (Foucault, 1977). The MHA, 1969 defined mentally disordered persons as the *mentally ill*, those with *subnormal intellect*, and *mental infirmity* arising from old age or brain injuries. Categorisation enabled the allocation of different classifications of persons requiring care into residential homes in the community to receive interventions more suited to perceived needs, thus continual removal from family. Categorisation also

---

[74] Lunatics Act, 1846.

[75] The Mental Health Act, 1969.

enabled possibilities to constrain access to the psychiatric hospital based on diagnosis, as witnessed in the United Kingdom and in Aotearoa New Zealand through the rise of residential homes for persons with learning, cognitive and neurological impairments in the 1960/70s.[76,77] Although the shift from institutional to community containment practices continued to exclude family involvement, it opened up the possibility for rehabilitation practices and of future family involvement in caring through circulating the notion that *community care* practices were safe.

Community Care Organisations as a Key Part of Mergence Into Community

Shifts in service provision, legislated through the MHA, 1969, provided spaces for new strategies for formal and informal admissions enabling the development of services in the community run by community organisations. Greater opportunities materialised for community responses that catered for specific populations including the construction of groups that linked hospital and community:

> The most important voluntary organisations concerned with mental health services are the Intellectually Handicapped Children's Society, Mental Health Association, Stepping Stones, and Recovery. There is also a large group of voluntary workers who visit Kingseat Hospital, and several hospitals have “Welfare Councils” and similar organisations of parents, relatives and well wishers.[78]

The emergence of voluntary organisations provided an initial space for family involvement in service delivery, such as through ‘welfare’ councils. They also provided alternative descriptions to biomedical understandings of madness. Recovery New Zealand, formed in 1966 in Christchurch, aimed to:

> assist in the rehabilitation of people who are mentally, spiritually, or socially disorientated and to foster better community understanding of these problems.[79]

Rehabilitation as a practice within *community care* was a significant rupture enabling *community care* to function. Inability for persons living long-term in institutions to integrate into community settings, discussed within the ‘The community mental

---

[76] Department of Health. (1969). *A review of hospital and related services in New Zealand*. Author.

[77] Spencer, D. A. (1977). The discharge of mentally handicapped patients to residential care. *British Journal of Psychiatry, 130*(2), 127-130. https://doi.org/10.1192/bjp.130.2.127

[78] Department of Health. (1974). *A health service for New Zealand: Presented to the House of Representatives by Leave* (p. 32). Author.

[79] Recovery expands in size and work. (1971, September 25). *Press,* p. 9.

hospital'[80] was made visible in practices through voluntary organisations, and peer support mechanisms (discussed below). Voluntary organisations acted as an apparatus for disciplinary tactics (Foucault, 1977) to support the deinstitutionalisation of the body; of those moving from the institution into the community. To support integration, alternative language materialised. Junctures between mental, spiritual, and social aspects of the person, along with the concept of rehabilitation, rejected a biomedical construction of illness and institutionalisation, signifying the community as the appropriate space for persons experiencing "disorientation", as opposed to persons with a mental illness. Changes in language also reflected anti-psychiatry notions of mental illness as a response to adverse social situations. Blurring categorisations between different populations furthered discourses that mental illness was normal and that anyone could be affected by it:

> Recovery is open to all people of all ages who are in any way mentally sick, whether they are receiving treatment or not, have been hospitalised for a definite type of mental illness or are just suffering from nerves and wish to forestall a breakdown. Among the objects and aims of Recovery, are the rehabilitation of the mentally and emotionally sick through friendship and group discussion.[81]

Friendship, linked with rehabilitation, noted the importance of social connection with health. Friendship through group discussions provided new forms of intimate relationships that broke boundaries between the diagnosed and non-diagnosed. Breaking boundaries separating the hospital from the community, the hospitalised and non-hospitalised, was noted as pivotal by the Department of Health in 1969 to disrupt common perceptions that mental illness belonged in the hospital:

> Traditional boundaries as between hospital and community or hospital and hospital either have to be very extensively modified or entirely abolished if a mental health service is to be seen in functional, rather than in architectural terms. Correlation of services in the community with services provided in hospital is essential. It cannot be too often reiterated that the "hospital" and

---

[80] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health.* Author.

[81] Recovery expands in size and work. (1971, September 25). *Press,* p. 9.

> "community" components are inter-related aspects of a total health service. They are not alternative types of service.[82]

Constructions of Community Care as a Right and Responsibility

Voluntary organisations provided the link between hospital and community to disrupt and dispel the need for incarceration except for extreme forms of illness. They emphasised the natural space for mental health as the community evaded the isolation from long term hospitalisation and its detrimental impact on functioning and relationships. However, the Department of Health in 1969 also sought to combine the elements of hospital and community to create a holistic service that enabled prevention of admission, and oversight of those re-admitted post-discharge. *Community care* became a tool for psychiatry to operate within the community under the veil of community responsibility, promoting self-responsibility and health service access as a moral, social right:

> If it can be accepted that sound health is a fundamental human right, then health services are a social service, and not a marketable product. Self-reliance finds its highest expression in community responsibility. This inevitably leads to national responsibility for the provision of health services. Splintering of this responsibility by private services therefore threatens to destroy an achievement of social progress in New Zealand. It is morally indefensible that the individual's access to services, which should be freely available by right, may be facilitated or obstructed according to his ability to pay. It is a responsibility of the State to provide a high standard of health care, available to all on an equitable basis.[83]

Social welfare philosophy drove the notion of *community care* as a responsibility of the State through the provision of services, and through the responsibility of the community and its members through self-reliance. Relations between State, community (organisations), and individual responsibilities constructed *community care* as an object that functioned within myriad domains. The Department of Health in 1974 recognised *equitable* health access to all as a human right and sought to find balance between overseeing service provision in partnership with voluntary organisations; therefore,

---

[82] Department of Health. (1969). *A review of hospital and related services in New Zealand* (p. 92). Author.

[83] Department of Health. (1974). *A health service for New Zealand: Presented to the House of Representatives by Leave* (p. 84). Author.

fostering community responsibility. Private services, soon to be noted as solutions with the shift to the neoliberal market within the next 10 years (see Chapter Six), were demonised. Responsibility and self-reliance emerged as discursive constructs for good health, constraining overall responsibility from the State as overall provider. Shifting responsibility into the community provided further opportunities to look at the nature of *who* was community, and possibilities for family to have rights and take on positions of responsibility in the future.

Rights also emerged in the MHA, 1969 for family to question decision-making constraining *community care*. The availability of ombudsmen and the right for appeal against decisions, (for adults), through the MHA, 1969, was declared in newsprint in 1970.[84] Possibilities for the *patient* and their family in decision making expanded through a process of appeal, as in the practice of discharge under Section 73(2) of the MHA, 1969:

> When the superintendent is of opinion that any such committed patient is not fit to be discharged, but an inspector or official visitor, or any relative or friend of the patient, is of a contrary opinion, the inspector or official visitor shall, and the relative or friend may, report the matter to the Minister.[85]

Within the legal framework, family had the possibility to act if they had a different opinion from the clinician, a space for agency. Similarly, within initial assessment, family had a 'provision for immediate repeal'[86] during the first 3-weeks of hospital stay and prior to a formal commitment process. Under a broad umbrella of rights, family opinion and agency began to emerge offering possibilities for the materialisation of *consultation* within a legal framework.

Further rights were detailed within the Act. Fines for misleading and false medical certificates (Section 111), and imprisonment and fines for the abuse or neglect of persons (Section 112), provided clearer rules of conduct than from within the preceding Mental Defectives Act, 1911. But as safer practices were encouraged to promote a benign and beneficent space within the hospital, danger shifted from the institution into the community through the deinstitutionalisation process:

---

[84] Psychiatric admissions changed. (1970, April 1). *Press*.

[85] The Mental Health Act, 1969.

[86] The Mental Health Act, 1969.

> In California, a combination of pretension and propaganda conned gullible and superstitious legislators into closing down State Hospitals so that some 30,000 patients were abandoned to a life of aimless destitution, wandering from derelict hotel to flophouse, from flophouse to park bench and from park bench to prison. Many of these ex-patients became half starved (cat food was a luxury), sexually abused, brutalized, physically neglected and verminous; at the mercy of petty thieves and thugs, spending their time in the unsupervised company of winos, drug addicts and prostitutes; many died and some were murdered. All but the very worst conditions in the State Mental Hospitals were better than the neglect and misery that awaited them in the community.[87]

Presented at the first Pacific Congress of psychiatry at Melbourne, Australia, the Director of Rochester Psychiatric Center, USA, cautioned against the spread of *community care* through scenarios of horror on an unsuspecting *patient* by the community. Family took on culpability through their absence as those released from hospital fended for themselves without adequate levels of support. The freedom of *community care* proffered new human rights concerns as reduced confinement meant reduced control of external variables on the body without rehabilitation or integration into society. Vulnerability through the absence of family during the first wave of *community care* in the 1970s became visible, a gap within the successful function of *community care*. Greater involvement of family became thinkable in the 1970s, but generally, not fully doable until the 1980s. In the first iterations of *community care* from the 1950s to the 1970s, an alternative form of familial assistance emerged in the form of peer support.

Section Summary

This section identified challenges to practices of committal for persons experiencing mental illness, promoting treatment in the community as an alternative. *Community care* was normalised by discourses constructing the mentally ill as normal people through changes in language from diagnoses to terms such as ‘emotionally disorientated’. The development of community-based homes adapted to meet the needs of different populations, including the *mentally ill,* became widespread and signalled *community care* as safe. Although underpinned by social welfarism, and thus greater State

---

[87] Barton, R. (1975). Abandoning the mentally ill. *Australian and New Zealand Journal of Psychiatry, 9*(4), 216.

involvement, health in relation with responsibility and self-reliance was constructed as a human right. Community organisations took on some responsibility for the rehabilitation of persons previously living in institutions to support their integration into the community. Rehabilitation as a disciplinary tactic to support community integration was a significant rupture from containment to care in the community, initially driven by voluntary organisations. A blurring between people previously committed and never hospitalised also promoted discourses of mental illness as normal and belonging in the community. To support the integration of persons previously hospitalised with those never hospitalised, community organisations shifted the language from medical notions of illness towards discourses similar to anti-psychiatry in that illness was a response to social adversity.

Rights and responsibilities in legal processes continued in the MHA, 1969 through family having the possibility to contain and care for their relative in agreement with a judge. However, The MHA, 1969 also provided possibilities for family to appeal decision made within legal processes through access to the ombudsman. Appeal provided a move towards increasing rights for family, supporting the possibility for *consultation* to emerge. The growth of voluntary organisations provided spaces for family involvement and agency; however, critique that *community care* constructed vulnerable persons on leaving the safety of the institution, highlighted the possibility for a lack of support, and the absence of family. A gap that could have been potentially occupied by family, as discussed in the next section, was filled in the interim through peer support mechanisms.

Psychiatric Reach Through Peer Support Mechanisms

The previous sections highlighted a shift in responsibility from the State onto the community, through practices of *community care*. Family, however, remained largely absent from within discourses of *community care*, potentially through the implication of family in the production and persistence of mental illness through factors such as stigmatising attitudes, anti-social practices, and being untrustworthy. This section analyses the tactic of peer support mechanisms to support practices of deinstitutionalisation, providing alternative iterations of the meaning of family.

The Strategy of Peer Support for Community Integration

As family had rejected, sometimes on medical advice, the care and responsibility for family members leading to incarceration, the Department of Health[88] reiterated strategies proposed by the WHO[89] to develop peer support networks. Peer support emerged in a way that I will argue functioned as a variation of family – constructed in the gap where institutionalisation had severed links between the *patient* and their family of origin. Peer support networks also supported new treatment spaces intersecting community responsibility and self-reliance (as discussed in the previous section). As with residential-type placements for specific populations (*subnormal intellect* and *mental infirmity*), *mentally ill* persons were identified by the WHO[90] as requiring spaces for habitation and rehabilitation.

Hostel accommodation to support the transition from the hospital into the community was suggested by the WHO[91] for previous *inpatients* who would likely struggle with the change of situation. The hostel, facilitated by staff with a basic knowledge of mental health, could facilitate appointments with psychiatric expertise as needed. The hostel was a place for persons undergoing outpatient psychotherapy sessions, and staff could support the stabilisation of health. Accommodation would be paid for by the person, signifying the shift from dependent to independent living, and their emerging responsibility and citizenship. Concerns of the transition to *community care*, its function, and a possible strategy, were noted by the WHO:

> When the patient leaves the hospital, one of two attitudes is often observed: either he tends to deny his illness and to sever all contact with the hospital and its doctors; or else he is overcome with anxiety caused by a more or less conscious fear that he will be incapable of confronting his responsibilities and supporting the moral isolation and, often, the sheer loneliness which await him outside. These two modes of behaviour, although apparently contradictory, show the persistence of an attitude with regard to the illness which may prevent resumption of normal social relations, and consequently impede the social rehabilitation of former patients. Old-patients' clubs have been found an

---

[88] Department of Health. (1969). *A review of hospital and related services in New Zealand*. Author.

[89] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[90] World Health Organization. (1953). *A review of hospital and related services in New Zealand.* Author.

[91] World Health Organization. (1953). *A review of hospital and related services in New Zealand.* Author.

> excellent way of meeting these problems. They are constituted by groups of old patients and are preferably run to a considerable extent by the patients themselves. In fact, such persons are more likely than any others to understand those who have undergone the same difficulties as themselves; their group constitutes, therefore, the most favourable environment for supporting the patient who has just left a mental hospital.[92]

Persons leaving the hospital after a long period of time could not be assumed to assimilate. According to the WHO,[93] they required intervention from others to become independent, functioning citizens. Family of origin missing as a provider for accommodation needs and as a support in the transitioning to independence, enabled a variation of intimate relations within the community. Peer support as a strategy for community integration was promoted on the basis of a better understanding of the context and difficulties arising from deinstitutionalisation. A blurring of the roles between staff and the person experiencing mental illness signified a shift of perceived expertise from clinicians onto the *patient*,[94] an example promoting technologies of self-care. Peers, constituting each other within their social rehabilitation, aimed to become individuals that functioned as *citizens* as opposed to *patients*.

This shift in position involved an acceptance of illness, thus enabling monitoring and guidance from psychiatry with less dependence on the service and clinicians. Hostels provided a space for communal living, sharing resources, skills, and strategies to self-direct conduct within an ethos of peer governance (Hilder et al., 2018). The space, enabling the possibility of intimate relationships, provided new iterations to the concept of family through inclusion and belonging. I argue that peer support as an important iteration of family in this context provided the conditions of possibility to limit dominance of family as a biological construct, providing possibilities for other definitions of family as appearing in Section 7A consultation (see Chapter Six).

Hostels enabled the strategy of normalisation. As noted by the Department of Health,[95] they had "the real advantage of enabling some patients to take a step nearer to normal

---

[92] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health* (p. 13). Author.

[93] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health.* Author.

[94] Jones, M. (1979). State mental hospitals and the future. *Psychiatric Quarterly, 51*(2), 151-160. https://doi.org/10.1007/BF01064564

[95] Department of Health. (1969). A review of hospital and related services in New Zealand (p. 96). Author.

life”. Shared experiences, notably diagnosis of mental illness and the practices of incarceration, enabled support mechanisms to overcome shared barriers, such as stigma, blocking community integration. “*Old-patients*”[96] acting as a form of pastoral power, could translate the concept of *community care* as promoted by services through experiential modelling, guidance, and potentially through liaison with hostel staff and service providers if problems arose. A panoptic form of surveillance from within peer relationships emerged: in an environment of caring and support, surveillance enabled the manipulation and internal management of behaviours suited to a new environment, to avoid (re)hospitalisation.

The Reach and Growth of Psychiatry Through Deinstitutionalisation

By the end of the 1960s, the Department of Health in 1963 touted the notion that persons achieving successful community integration through hostels could integrate back into their family of origin. However, barriers to reintegration with family was noted through discourses of economics and practicality, such as geographical location and staffing levels:

> It is currently fashionable to lay too much emphasis on the importance of providing psychiatric treatment as close as practicable to the patient's own home. As a generalisation this must receive support. It is, however, subject to certain limitations:
>
> (i) It is impractical and uneconomic to disperse specialised psychiatric services too widely. This observation applies with particular cogency in the present situation of acute shortage of experienced psychiatrists and supporting staff.
>
> (ii) It will not normally be economic in terms of psychiatric staff to provide a specialist service for a population of less than 50,000. (This figure will sometimes have to be modified in the light of special geographic factors).[97]

Practicality, as a discursive construct, provided a hierarchal position of needs; in this case, the needs of the service over the importance of proximity to family. Psychiatric expertise on the successful (re)integration of persons from the institutions was used as tactics to maintain psychiatric dominance within the shift of service provision,

---

[96] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[97] Department of Health. (1969). *A review of hospital and related services in New Zealand* (p. 92). Author.

impacting other players, such as family. Psychiatric discourse extended its reach into the community through practices such as the availability of services, creating forms of dependency and maintaining and creating ‘new’ positions constructed by psychiatry (Rose, 1999), such as the *outpatient*. Shifts into the community supported the growth of psychiatry through new possibilities of practices that expanded into the conduct of those now living in the community. *Community care* extended the reach of psychiatry into the community initially through the *patient*, later (as discussed in this and the next chapter), back into the family. Constraints arising from the primacy of psychiatry through service availability in the community supported the growth of community/voluntary agencies and peer support as mechanisms supporting rehabilitation and integration into society. Peer support mechanisms were seen as advantageous for integration, using psychiatric discourse in shaping conduct; and, although I have argued they provided a variation to the meaning of family, they did so within a Eurocentric gaze on non-biological variations of family.

Section Summary

This section identified the space of the hostel, acting as a strategy for deinstitutionalisation, provided possibilities of intimate peer relationships within the community. Peer support intersected with discourses concerning citizenship, personal responsibility, and self-reliance. Responsibility and self-reliance were placed on persons leaving the institutions and not correlated with family. Family remained limited within processes of deinstitutionalisation, in part through a perception of their lack of understanding but also through other factors such as proximity to service providers. The factors acted as potential barriers to *consultation*. Notions of practicality, such as the distance of the family home from services, economics, and staffing of services, limited family participation and extended the reach of psychiatry as a dominant decision maker in *community care*. Peer support mechanisms were strategized as an alternative strategy to reinforce notions of citizenship and reintegration into the community, thereby providing a disruption to the definition of family as biological through providing another variation. Practices of deinstitutionalisation, including the use of community agencies and peer support mechanisms highlighted Eurocentric tactics, and thus the exclusion of non-Western discourse.

A Eurocentric Gaze

In the above section I argued that peer relations were constructed by psychiatry as a variation of family to support deinstitutionalisation practices. The use of voluntary organisations and peers reflected a Western-centric approach to deinstitutionalisation and *community care* practices. This final section of the chapter, noting that analysis within this chapter so far has been Eurocentric in nature, analyses non-European people and families in relation to mental illness and mental health service provision. Analysing discourses subjugated by Western knowledge during this time period highlights discourses as particularly problematic when referring to Māori and Pacific people.

The Taken-for-granted Norm of Western Family Structures and Practices

Text concerning mental illness within the shift to community care constructed non-Western people and families, specifically Māori and Pasifika, against taken-for-granted European norms. Discourses of racial differences and similarities between Europeans and Māori were found in newspaper articles and research. In an article in the *Press,* discourses promoting equality, and thereby similarities in treatment for Māori and Europeans, was proposed by the Bishop of Aotearoa in 1971:

> Too much was made of the psychological differences… a Maori and a European did not undergo different psychiatric treatment for mental illness just because one was Maori and one was pakeha… the approach to a Maori who had offended against the law was the same as the approach to a European offender. Both should not be protected against the law, but realise that life was made up of rewards and punishments… the first step in improving illegal behaviour in both Maori and European young people was an awareness by the young people themselves.[98]

The reporting of this *special conference* on relations between Māori and the church, by focusing on mental illness and illegal activities, situated Māori as particularly problematic through association with deviant conduct. Mental illness, through comparison with illegal behaviour, constructed discourses of deviance emerging through lifestyle choices and the values of a younger generation. The minimisation of differences arising from culture or race supported the dominance of Western norms and approaches, with deviation from social norms accruing punishment. Maturation and the

---

[98] "Too much made of differences. (1971, November 22). *Press,* p. 12.

restoration of relationships, noted by the Bishop as effective therapy, spotlighted consideration of psychosocial factors. Discourses critiquing comparison, including statistical, such as found in the Department of Health's 1962 report of comparing numbers of Māori and European in psychiatric hospitals, imparted similar notions:

> The whole point I am trying to make here is that the 'racial' division between Maori and European is artificial as far as mental health is concerned. Mental illness involves the breakdown of individuals within their particular social environment; the basis of sociological interest in such breakdowns lies in the attempt to discover as precisely as possible the combinations of social and cultural factors that are conducive to health or illness. Presumably these factors will be the same whether a person is Maori or Pakeha.[99]

Acknowledgement of similar psychosocial factors impacting Māori and European health and illness, but ignoring factors specific to experiences such as arising through colonisation and marginalisation, provided spaces that lacked consideration of unique cultural influences on health. However, when focus was provided on cultural differences, the notion of being Māori became more problematic. This argument is explicated in Chapter Eight.

Pathologisation of Non-Western Family Practices

In a USA research article authored by the 'Bureau of Testing and Research', acculturative stress and the role of the family was noted as important in the precipitation of illness, gathered through an objectification of Māori from ethnographic anthropological studies:

> In attempting to understand the stresses involved in the process of acculturation, it is essential to give consideration to the model personality of the Maori. Fortunately the research program of James Richie and his associates has provided detailed data on the personality development and dynamics in the Maori culture... In the first 2 years of life, the Māori child receives considerable attention and indulgence from the parents. At age 2 or 3 there is a sharp break in the parent child relationship in which the adult support is withdrawn and the child is left largely to his own resources. This "abandonment" typically does not

---

[99] Reviewed work(s): Maori patients in mental hospitals. Department of Health Special Report no. 8 by F. H. Foster. Review by Alan Howard. *Journal of the Polynesian Society*, p. 53.

> take the form of a hostile rejection… The experiences of rejection in early childhood have a lasting influence on the Maori personality.[100]

European anthropological discourse, resulting from a Western modernist gaze, situated Māori culture as a static entity through an ethnographic lens, thus 'othered' through comparison with Western norms. Situating Western practices within an unquestionable hypothesis as advanced, and thereby other cultures as primitive in comparison, enabled the dominance of Western discourses and subjugation of other discourse concerning health and citizenship. Subjugation can be seen from within the above text, where this study, circulated as research, claimed specific practices as representative of the whole society, enabling objectification (Bowman, 2003). The above text constructed Māori as deviant from Western and psychiatric discourses through the notion that collectivist cultural norms were unhealthy, negatively impacting personality. Māori parenting techniques were thus particularly problematised as a generator of mental illness through perceived cultural deviancy. 'Othering' contributed to the rejection of Māori practices, and thus the invisibility of Māori family practices in this time period (see Chapter Eight).

Spaces, such as the church conference and Kelly's research, provided a rejection of Māori culture through norm deviance and conceived deficiencies, such as parenting style. Parenting, absent in the church conference and present in Kelly's research, was presented as causal for deviance and illness, but with a specific emphasis on the role of culture. Relations between Māori parenting, psychiatric illness, and crime was circulated, such as within this law journal from the 1970s:

> The risk of a Maori boy coming before the Children's Court by age 16 is about four times greater than for a non-Maori boy. The crime rate of Maori's is five times that of the general population. Behind bars in New Zealand 41 per cent of the males are Maori; 60 percent of the females are Maori; and 60 per cent of the Borstal boys in 1972 were Maori (and in the mental hospitals, a large proportion of the patients are Maori). The schizophrenia of the Maori's is assessed as their difficulty in maintaining a dual cultural identity, or possibly in choosing one set of cultural values.[101]

---

[100] Kelly, R. (1973). Mental illness in the Maori population of New Zealand. *Acta Psychiatrica Scandinavica, 49*(6), p. 729. https://doi.org/10.1111/j.1600-0447.1973.tb04461.x

[101] MacIsaac, R. F. (1977). *Who's in jail*, p. 1

The arrangement of statistics presented in the above quote normalised Māori as deviant in relation to crime through only making visible the rates for Māori. Cultural assimilation, acculturation, or separation from European norms through a rejection of assimilation all led to the development of psychiatric illness. Being Māori signified a form of criminal deviance witnessed through an inability to integrate into European society, leading to psychiatric illness.

Immigrant Polynesian families were also represented as disadvantaged and deviant. Higher levels of crime were associated with communal living and extended family systems:

> Society consists of extended families, and within the village group there is communal ownership of all things. This, in a materialistic society, leads to thieving, car stealing and shop-lifting, which many Samoan adolescents will justify in terms of their sharing concepts.[102]

Religious conflict, social disintegration, and loss of identity were used by Gluckman in research in the *Australian and New Zealand Journal of Psychiatry* to discursively construct Samoan people as a "culturally deprived group… with culturally determined syndromes".[103]

> Ethnopsychiatry has three separate levels of diagnosis. The first of these levels is the evaluation of the patient's biological function. The second level is the evaluation of the concepts of the patient and his family. This presumes honesty by the patient family. The first and second levels of evaluation frequently conflict. The third level of evaluation is the more difficult level of the patient's culture… Culture bound disorders serve to bind the patient to symptom.[104]

Relations between the body, the patient and the family, enabled further possibilities to mistrust the confession of the person and their family, as the biological body was constructed as the 'truth'. Samoan social norms, witnessed, as with Māori through 'otherness', and examined within a deficit gaze produced a triangulation of strategic relations, comprised of extended family, illness, and criminal activity. Indigenous

---

[102] Gluckman, L. K. (1977). Clinical experience with Samoans in Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 11*(2), p. 104. https://doi.org/10.3109/00048677709159545

[103] Gluckman, L. K. (1977). Clinical experience with Samoans in Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 11*(2), p. 101. https://doi.org/10.3109/00048677709159545

[104] Gluckman, L. K. (1977). Clinical experience with Samoans in Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 11*(2), p. 107. https://doi.org/10.3109/00048677709159545

constructs of family and health were supressed through negative stereotyping and European racial intolerance of the ‘other’.

Resistance Through the Resourceful Mother and Good Health

Spaces for challenging dominant constructions of people through a Western cultural lens were limited. In my research of this period, Western notions dominated the data available for analysis on family and the emerging possibilities for *consultation*. However, resistance to the subjugation of parenting values emerged in positive relations with health through a Māori lens. At a conference for the Māori Women’s Welfare League the invisibility of the key role of Māori females with whānau wellbeing confronted European anthropological discourse linking Māori with deviance and deprivation:

> Home furnishing and upkeep, budgeting to make ends meet, managing the Family Benefit and the buying-on-instalment plans, caring for the children and keeping up with the ever-increasing complexity of modern life—all these are tasks that we take in our stride—or most of us do, anyhow. Probably the greatest achievement of Maori women is reflected in the steeply rising standards of health among our people. If at first you credit his great improvement to the developments of modern medicine and the extended medical services now available, you should remember that the application of these services and their ultimate success generally depends on the mothers.[105]

The production and circulation of discourse linking good health with Māori practices provided possibilities for an alternative construct of Māori within mental health service provision. However, positive constructs of Māori aligned with engagement in European discourses and norms. Constraints placed on Māori practices from Western discourses, including psychiatry, were made more visible towards the end of this period of analysis in my research. Increasing protests in the 1970s over the loss of land and resources, culminated in the establishment of the Waitangi Tribunal as an avenue for reparation (Mutu, 2018), and a space for greater activity in practices concerning Māori by Māori, including agency in mental health service provision. Greater visibility of Te Ao Māori (worldview and cultural practices) is explored in the following chapter.

---

[105] Penfold, M. (1960). The status of Maori women. *Te Ao Hou, 30*, p. 62.

Section Summary

In this final section I have argued that non-Western practices, including collectivism and the extended family system, were linked to the development of mental illness through othering. Māori and Pacific Island people were often positioned in relations with crime and mental illness from within European anthropological discourses, surfacing in research and media, and fixing their worldview and cultural practices as primitive and deviant. However, resistance to the pathologisation of non-Western family practices emerged through notions of good parenting and the application of services to improve health, providing alternative possibilities of doing, even if constructed within Western discourses. The subjugation of Māori knowledge functioned to shape the emergence of *consultation* within Western constructs; an argument expounded in Chapter Eight.

Chapter Summary

This chapter analysed data from the 1950s to the end of the 1970s, a significant rupture in thinking about and doing *community care* in Aotearoa New Zealand. In my analysis I argued that psychiatry extended its reach into the community through deinstitutionalisation practices and through seeking out stress and mental illness in the community to reduce rates of hospitalisation. Biomedical and public health discourses extended psychiatry through public health workers acting to translate mental health discourse into community settings. A gaze on intimate relationships within the family unit supported the construction of family as a site for the emergence of stress and illness, occurring throughout the developmental life cycle. Constructing the family as sick, deviant, or stigmatising, provided opportunities for their inclusion in treatment in hospital and community spaces. Disciplinary tactics through community outpatient departments, voluntary community agencies, and the mechanism of rehabilitation, acted as interventions on the family to reduce factors causing illness development. With family as also sick, mental illness in the community was problematised and normalised through the media reporting statistically high prevalence, and the warning that anyone was susceptible to illness.

By the 1970s, the space of the psychiatric hospital was opened up to the general public as a safe but temporary space for persons with acute or significant illness. Constructing long-term incarceration as unnecessary and objectionable, through representing *patients* as ‘normal’ people, furthered the notion of mental illness as belonging in the community. Reducing hospital admissions provided greater possibilities for family inclusion; however, to assist the deinstitutionalisation of persons who had been committed long-term in the hospital, peer groups as a mechanism for rehabilitation and community agencies supported the shift to care in the community. Family continued to be a subsidiary strategy for *community care* through being represented as stigmatising, unreliable, and causative of illness. Women and non-European people were constructed as particularly problematic, through discourses positioning particular traditional gender roles and non-Western parenting practices as conducive to illness development. Politically, social welfarism supported the State to remove those represented as vulnerable persons from the family unit, sanctioning exclusionary practices. The problematisation of the family as sick or generating illness was, however, one step toward enabling possibilities for *consultation* through their examination, and thereby inclusion in mental health service provision.

Resistance to psychiatry arose through the antipsychiatry movement. The notion that social adversity, rather than the ‘faulty body’, led to the generation of illness, supported representations of the family as unreliable. However, texts from the 1970s increasingly recognised the family as needed within *community care* practices, creating spaces for communication. The MHA, 1969 also reiterated rights for family involvement in legal processes, promoting reporting of information from family to judges and clinicians, supporting greater family involvement and future possibilities for *consultation*. However, the conditions of possibility for *consultation* emerged through positioning family and whānau as sick, deviant, stigmatising, and untrustworthy.

Prior to the period following World War II, family had been excluded from the responsibility of caring for a member diagnosed with a mental illness through practices of long-term incarceration. The dominance of discourses criticising and censuring family from the 1950s to the end of the 1970s actually supported a shift towards their inclusion. The next chapter of analysis from the mid-1980s witnessed a shift towards increasing their involvement and ultimately family and whānau responsibility. This shift provided greater opportunities for the materialisation of *consultation* as a practice within compulsory assessment and treatment.

Chapter Six: Familial Responsibility and the Construction of Partnership (1985–2000)

Introduction

In the previous chapter, my analysis identified that critique and censorship of family, contextual to the development and maintenance of mental illness, enabled possibilities for their inclusion in mental health service provision. Discourses, including biomedical, psychiatric, antipsychiatry, and public health, predominately positioned family as causing or exacerbating mental illness. Educating family to reduce stress within intimate relationships and integrating family members into assessment and treatment practices, acted as strategies to reduce the prevalence of mental illness within the community. Educating family on mental health and barriers to inclusion, such as stigma, acted as strategies supporting deinstitutionalisation and the shift to *community care* practices. Greater inclusion of family members in practices provided possibilities for iterations of communication between family and clinicians, enabling possibilities for the future construction of Section 7A *consultation*.

This chapter explores texts produced from 1985 to the end of the century, a period that culminated in the inclusion of *consultation* in the MHA, 1992 as a formal practice. The period is chosen for analysis as the period is notable for the rise of a significant critique of *community care* practices, including the lack of agency and participation of family and whānau. The notion of *risks,* arising from significant events in the community, promoted community mental health service inquiries and evaluation, significantly through two reports chaired by Judge Kenneth Mason (Mason et al., 1996; Mason, 1988). These two reports are noted as key texts within this period of analysis, as they supported critique on the lack of government policy contextual to *community care.* Moreover, they provided a space for family and whānau agency through the right to speak on previously veiled concepts, such as relations between lived experience and expertise.

This period of inquiry also witnessed a rapid shift from social welfarism and State responsibility prevalent in the preceding 3-decades to neoliberalism, witnessed through a prioritisation of a market economics over a social welfare focus. Neoliberalism enabled possibilities to construct family and whānau in ways to meet the demands of a market-driven productive-focused society, providing different opportunities for their inclusion in service provision. This chapter presents an intersection of discourses arising from political and cultural domains that led to the construction of *consultation* within Section 7A of the MHA, 1992.

The chapter begins with the problematisation of *community care* which initially appears through discourses of *risk*, and how *risks* were positioned to signify responsibility and ‘quality of life’. This period is notable through the emergence of ‘experiential expertise*’* providing possibilities for a right to speak for family. Concurrently an emerging *burden of care* discourse critiqued a hidden assumption of *caregiving* as women’s natural role, especially as it related to care of family members. A family model of care represented the normalisation of *community care* and of the rightful position of family to care in the community. At the same time, there was a questioning of what the role of the family should be.

The next part of the chapter analyses the problematisation of rights, where the legitimisation of *patients’ rights* in the early 1990s made visible a lack of family rights. Significant critique from family questioning the right to care, but not necessarily provide care, potentially threatened the concept of *community care*. Critique from Western family largely upheld the authority of biomedical and psychiatric discourses, with concerns about the lack of agency in decision making. Critiques of biomedical discourse and the authority of Western practices was more apparent from Māori regarding their involvement within the institutions.

The final part of the chapter analyses how policy and supporting documents in the 1990s formalised *community care* practices and family as responsible *caregivers*. The concepts of *partnership* and *working relationships* provided opportunities for the integration of Māori and Western thinking in relation to family inclusion. These two concepts also provided possibilities to shape family and clinicians within clinical governance strategies. The chapter ends by noting how historical socio-political discourses constructed *consultation* as a discursive paradox.

The texts analysed to produce the findings for this chapter could be classified into four categories: texts that guide and regulate practices (e.g., policy and guidelines); Acts of law; articles from media and research; and articles and letters appearing in publicly available publications that document experiences and practices.

Responsibilisation and the Emergence of Familial Expertise

The Intersection of Responsibility and Risk in the Problematisation of Community Care

An inquiry into the function of mental health law and procedures concerning admission, discharge, and leave for persons in a psychiatric hospital was requested by the Minister of Health in July 1987. Generally known as the ‘Mason Report’ (as the committee of inquirers was chaired by Kenneth Hector Mason, District Court Judge), the status of mental health service provision came under formal investigation following a double homicide in a boarding house and several suicides in prisons in Auckland in 1986 and 1987. Questioning relations between hospital and *community care* and law, Mason noted the concealed nature of service provision and those providing services:

> It seems to us that the wider community is entitled to know something of the character, attitudes and beliefs of those who are responsible for making decisions affecting our psychiatric patients. Ultimately, those decisions affect not only the quality of life enjoyed by patients but also their care givers and the wider whanau of family and community.[106]

The report was written at a time bereft of explicit, published government policy on the provision of *community care*; hence, an initial concern by Mason regarding the transparency of decision-making impacting a range of stakeholders. The shift towards care in the community was questioned, in the above text, through interrogating decisions that potentially impacted elements of the ‘quality of life’ construct: health, education, work, wealth, relationships, and the social status of those receiving services, and their family and whānau. Quality of life was offered as a ‘new problem’ (Rose, 1999) arising from the identification of faults, service gaps, and ineffective processes constructed as poor service delivery within the notion of *community care.*[107] This, alongside events resulting in deaths which occurred in the mid-1980s, provided the conditions for the Mason report to problematise *community care*.

Discourses circulating in the early stages of neoliberal reforms in Aotearoa New Zealand and other nations provided opportunities for critiquing responsibilisation,

---

[106] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 10). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

[107] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 10). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

where individuals take on responsibilities previously held by the State, or where the responsibility had not previously existed (Larner, 1997; Rose, 1993; Taylor & Grey, 2014). Prior to the shift to *community care* practices, responsibility of persons diagnosed with a mental illness had been held by the institution of psychiatry and the staff. With the shift towards *community care*, clarity on who was responsible was, according to the Mason report, missing. The problematisation of responsibility within *community care* practices provided conditions for family involvement which, as noted in the previous chapter, had been relatively absent.

Responsibility was noted as a concern when constructed in relations with dangerousness and safety, core concepts shaping the Mason report. The ethics of managing and reducing negative constructions of *risk* emerged as prevalent discourses in the 1980s, as witnessed through the Mental Health Act, 1987 [MHA, 1987], repealing the Mental MHA, 1969. The following explanatory note in the introduction to the MHA, 1987, entitled as the ‘central dilemma’ constructed *risks* with responsibility, and human rights through the notion of treatment consent.

> Perhaps more than any other area of law, mental health law is bedevilled with questions that are probably unanswerable. The underlying question can be simply stated: in what circumstances should a civilised society insist on treating a mentally disordered citizen who is incapable of giving consent or, worse still, is capable of giving consent but refuses to do so? Supplementary questions include-
>
> (a) Is Society ever justified in insisting on non-consensual treatment on the ground of the interests of the patient himself or herself, or is such treatment only justified on the ground that the patient is a danger to others?
>
> (b) Conversely, is non-consensual treatment of a patient ever justified on the ground that the patient is a danger to others?
>
> (c) If non-consensual treatment is rejected as being too invasive of human rights, what is to be done with the patient who, untreated, is a danger to others?
>
> (d) If the answer to question (c) is some form of detention, what form and in what type of institution?

> (e) Where decisions are to be made in such cases, who is to make them? Doctors, on the ground that they are essentially medical questions, or Judges on the ground that they are matters of civil liberties?[108]

Consent signified a person's own responsibility for engaging in treatment (Skipworth, 2013). As a referent within mental health law, issues with consent, represented as either inability to give consent or a refusal to, was proposed as the *central dilemma* of the 1987 Act: A problem of rights which had become more visible within *community care*. Human rights made visible tensions of conflicting responsibilities between services, the *patient*, and others. Civil liberty of the 'disordered' individual within a 'civilised' society enabled the ascension of rights through strategies of accountability and responsibility in relation with dangerousness.

The Emergence of Familial Expertise

The question of whether doctors or judges should make decisions regarding compulsory practices highlighted the continuation of an authority to speak based on historical professional legitimacy. Legitimacy of psychiatry had limited the right to speak 'psychiatric matters' inside the hospital. Within the community the possibility for other voices was seen to challenge the authority of psychiatry, as noted in the following submission to the MHA, 1987:

> I cannot understand that lawyers, judges, or police are at all qualified to decide whether a mentally disturbed person is either sick, or well. They have not been trained in psychiatry, nor have they suffered from a chemical ('mental') disease, nor have they observed the patient, but can only take advice from psychiatrists, as to whether treatment should continue or not. Most importantly their next of kin should be given information and especially informed… so that they are prepared for any eventuality. The regular pill-taking should be emphasised. Depressives' relatives should compulsorily be warned of the danger of suicide, and the necessity to encourage and watch the patient.[109]

The above quote, written by a self-stated service user, proposed that responsibility should be maintained by psychiatry through its authority from training and qualifications. Psychiatric expertise provided the authority to manage the patient and supply information to the judge, the police, and to the family. For family to manage

---

[108] The Mental Health Act, 1987 (p. i).

[109] T. C. (1988, February). Submission to the Mental Health Bill, 1987.

risks and safety in the *community care* context, there was an obligation for psychiatry to share information, disciplining the family in psychiatric discourse, and thereby shaping individuals that could meet the specific needs of psychiatry (Foucault, 1977). Medication oversight and awareness of suicide and other behaviours of concern imparted a justification, and an obligation for the examination of an individual by their own family. Family, as noted in the above text, were positioned as 'watchers' and 'encouragers', with a right to receive that which could prepare them for their responsibilities. The positions of 'watchers' could also be harnessed as a strategy for maintaining the dominance of psychiatry within the community. Positioning family to follow the directions of psychiatry, and to watch and provide oversight upheld the expertise of psychiatric knowledge and the dominance of biomedical discourse within family relationships. Psychiatry, in disciplining the family to take on responsibility for their family member, could provide the necessary tactics and strategies for the effectual operation of *community care.* Family could take on the gaze of psychiatry; however, the gaze would be redundant without speaking rights.

Through disciplinary techniques shaping and constructing the family to provide oversight and care, possibilities for family to make claims of expertise emerged. This served to contest the absolute authority of clinical and judiciary knowledge and the absence of knowledge from the family's own forms of expertise, especially in relation to care decisions. The following submission to the MHA, 1987, from a family member, identified a concern regarding speaking rights:

> I am concerned that the power of decision is almost exclusively the right of psychiatrists and/or members of the judiciary. I acknowledge that these professionals are experts in their fields and I would not question this expertise, but they almost certainly lack one advantage, the unique experience of having to live day by day with relatives who have recurring mental disorders. Thus, in many cases, probably not all, the applicant is the real expert and should be consulted.[110]

Submissions to the MHA, 1987 from family members noted concerns when family were constrained from speaking. These included the possibility for those under services to conceal important information, whereas family could provide a 'truth' from lived experience. Dialogue between services and the family member about these concerns

---

[110] Anon. (1988, February 18). Submission to the Mental Health Bill, 1987.

constructed alternative expertise through bearing witness (Rose, 1999). As a witness, family could report changes in behaviours within the classification systems of psychiatric concepts to assist services to respond to situations, such as deteriorating mental health. Lived experience constructed as a form of expertise provided family an authoritative position as *caregiver* requiring the practice of *consultation*; represented in the above text as a right to speak. In another submission to the MHA, 1987, expertise in relations with speaking rights offered services the opportunity to prevent deteriorating mental health:

> I ask you to try living with a psychiatric patient for one week – I can guarantee that after 2 days you will know what it means for the caregiver to want their thoughts heard and help be given to the patient before their condition is allowed to deteriorate too far.[111]

The construction of lived experiences as familial expertise enabled the possibility of an uneasy alliance of expertise between family and psychiatry to emerge. Alliance provided opportunities for mutual assistance and aligned with the political aims of shifting away from hospital focused care towards care in the community. Familial expertise, in alliance with psychiatry, acted to employ the technologies of governance producing *community care* and technologies of the self in managing the illness within the home (Rose, 1999). In the preceding decades, as discussed in the previous chapter, the outpatients clinic was constructed to resemble the family home. Towards the end of the 1980s the possibility for reversal emerged; the hospital space ceased being a familial space, as the family home offered itself up as a clinical space (Taylor, 2012).

Section Summary

In this section, my analysis has identified the Mason report as an emerging authoritative space for the problematisation of *community care.* An intersection of discourses of responsibility and *risks* was key in problematising *community care* through the notion of ‘quality of life’. The MHA, 1987, paralleled concerns with responsibility, accountability, and danger through the concept of consensual practices. Questions of who should be responsible (if not the *patient*), in the shift towards care in the community provided spaces for critique. Doctors and judges, the main decision makers for compulsory hospital admission and discharge, claimed their authority over *community care* practices involving compulsory assessment and treatment through

---

[111] J.C. (n.d). Submission to the Mental Health Bill, 1987.

historically constructed professional expertise. Yet, through the construct of deficiency of responsibility in the early days of *community care*, an alternative form of expertise emerged as critical to its success; that of the family through lived experience. Within the transition towards *community care* family materialised with the potential, if disciplined within psychiatric discourse, to assist service provision through an alliance of expertise. In order for the familial home to shift into a clinical space, however, the family required the right to speak and be heard. The emergence of familial expertise provided the possibility for *consultation* through situating family with knowledge that could be useful for service providers.

The Right to Speak and the Rise of *Burden of Care* Discourse

The last section identified that in order for the family home to shift into a clinical space, the family's right to speak and be heard was integral for successful *community care* practices. In this section, the right to be heard also enabled the emergence of a *burden of care* discourse, through direct relations with service provision. Limitations, including financial, on *caregivers* also emerged as issues of equity and rights through feminist discourse along with critique of services as male dominated.

The Construction of Family as a Support Network.

In the previous chapter, the WHO[112] had identified the boarding houses as a strategy for community integration and the development of peer relations an alternate version of family through support networks when the family of origin or whānau were absent. Family, in committing their relative to long term care, often on medical advice,[113] had relinquished positions of support and care in an ethos of institutional and social welfarism. In contrast, the familial home was noted in the Mason report as a tactic of support for reducing hospitalisation:

> Often families and friends are concerned as to what will happen when a patient returns home. They are sensitized at the disruption caused by acute episodes, and the unspoken thought, "when will he / she do it again", prevails. As the needs of the patient exceed the coping capacity of their friends, relatives and social networks, the patients drift into supervised boarding homes or rest homes. These may be in suburbs away from their own support networks, and often in

---

[112] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[113] Department of Health. (1969). *A review of hospital and related services in New Zealand*. Author.

> the absence of any support programmes attached to the boarding houses. Patients may therefore be alienated from friends and familiar surroundings… This lack of support, and dislocation from the networks that had helped them in the past soon results in deterioration and relapse of illness, often leading to readmission.[114]

Family and friends affected by the *patient* were constructed as an important social network and a tactic to support wellness in the above text. Dislocation from community supports was directly related with deterioration, relapse, and hospital admission. The family home had shifted from being a site for the emergence and maintenance of illness, as analysed in the previous chapter, to a site of potential amelioration and assistance. However, of concern in the Mason report was the lack of knowledge family held regarding illness and associated behaviours. Constructing the family as a support network enabled the possibility for the emergence of family as vulnerable to burden through an inability to cope with the stress of supporting, especially that of the unknown. Fear of relapse and lacking knowledge to manage future episodes of acute ill health authenticated the emergence of *burden of care* discourse.

In 1993 the government established a panel, again headed by Judge Mason, to identify resources underlying the provision of mental health services for persons experiencing acute and semi-acute mental disorders. The published inquiry identified ‘quality of life’ concerns stemming from the *burden of caring*. The following example was typical of these texts through highlighting concerns with service (in)actions and support:

> A mother-in-law: All of J’s symptoms were present on 2 December 1993. The fifteen weeks delay in getting treatment resulted in the stress of arrests and overnight stays in police cells for J, her children’s increasing pain and confusion, the family’s substantial fear and stress, financial costs in the loss of J’s money and car, property damage and legal fees, and most significantly, J’s complete mental deterioration. Also she is now “streetwise” and this has serious implications if she relapses. All of this and more could have been avoided, if the

---

[114] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 137). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

> Team had accurately assessed J. and admitted her to hospital on 2 December 1993, or had provided us with proper assistance after that time.[115]

Stress arising from intimate relations within the family unit was a key concern of the WHO[116] in reducing the prevalence of mental illness within the community. Trusted health professionals were tasked with seeking out stress within the family unit in order to provide education and tactics to reduce and eliminate the causes of stress (see previous chapter). In the above text, health professionals were identified by family as generating stress within intimate relations through a lack of appropriate and timely service provision, such as assessment and admission procedures. The above quote from a family member, showcased 8-years later in the Mason inquiry,[117] endorsed direct relations between responsibility for service provision, resources, and positioning the family unit as *at-risk* (of poor 'quality of life') if taking on the *caregiving* role. Who was available to take on the *caregiving* role also emerged as a potential problem.

Resistance to Gender-based Burden of Care

Relations between 'quality of life' and *caregiving*, particularly problematised through discourses of gender and *burden of care*, materialised in the 1980s. The following submission from the 'New Zealand Women's Health Network' on the MHA, 1987 problematised the financial limitations arising from *caregiving* as gender discrimination:

> We believe that the greatest burden of providing community based services falls on women and that this is an unfair burden generally placed on women who are not paid for their efforts. We believe that the provision of community treatment must go alongside the provision of adequate financed resources and these resources must be made available to the community at large, and to particular communities, such as Maori and Pacific Island communities, to meet the specific needs of the individuals who come from that background.[118]

---

[115] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services* (p. 24). Ministerial Inquiry to the Minister of Health.

[116] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health*. Author.

[117] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Ministerial Inquiry to the Minister of Health.

[118] New Zealand Women's Health Network (1988). Submission to the Mental Health Bill, 1987.

The submission noted cultural norms dictating female members of the family to take on the position of *carer* when a family member became ill. In the above text, the strategy of *community care* was noted as capitalising on the historical association between women and practices of intimacy, contextual to child rearing and looking after family members when generally unwell (McLennan et al., 2004). Noting financial *burden of care* arising from unpaid work such as caring, the 'New Zealand Women's Health Network' and similar groups in the 1980s mobilised feminist economic discourse concerning the lack of economic measurement on household activities. Unpaid work arising from *community care* as a rights based discourse made visible the relations between *community care* and the marginalisation of women, specifically those identifying as Māori and Pacifica, further marginalised through ethnicity (Waring, 1997, 2004). Mental health services were also critiqued for their lack of value of 'feminine' qualities, as in this submission from the 'Wellington Women's Health Collective':

> There needs to be more of women's qualities such as nurturing, love and emotions evident both in the awareness of mental illness and in all the services involved with the mentally ill.[119]

The notion of women's qualities needed within service provision constructed relations between *community care* and a family *model of care*, as proposed by Dalley.[120] In comparison with the institution, the construction of *community care* as something closer to the caring and love within families normalised the position of women as natural *caregivers* within *community care*:

> The women of New Zealand have always been worried about the casual use of the term "community care", believing that it is frequently a euphemism for women's care. They have been concerned that once people are out sight of the health service providers, they no longer matter.[121]

Burden of care for women, arising through the societal expectation that they support persons experiencing mental illness in community settings, enabled possibilities for comparison critique; such as, the 'quality of life' of one group (the *mentally ill*)

---

[119] Wellington Women's Health Collective. (1988, March 3). Submission to the Mental Health Bill, 1987.

[120] Dalley, G. (1983). Ideologies of care: A feminist contribution to the debate. *Critical Social Policy*, *3*(8), 72-81. https://doi.org/10.1177/026101838300300804

[121] National Council of Women of New Zealand. (1994, July 22). Submission to the 1994 MHA amendment.

impacting the ‘quality of life’ of another group (women).[122] A *family model of care*, as proposed by Dalley, circulating to normalise *community care* and *caregivers* is an example of the tensions between reinscribed historical notions of the female *carer*, and critique of this position within the context of rights.

Section Summary

This section analysed relations between the construction of family as a support system and the emergence of *burden of care* discourse through expanding spaces for family to speak. The Mason inquiry,[123] in providing spaces for the experiences of family to highlight burden, reiterated earlier concerns in the Mason report[124] regarding the impact of service responsibility and actions within *community care* practices. Relations between service responsibility and ‘quality of life’ for family and persons under services, as analysed in the previous section, incorporated *burden of care* discourse as a potential barrier to community support systems. Feminist discourse noted women as the unspoken, main care providers arising from historical constructions of women as *caregivers*. Services provision could thus be critiqued as discriminatory towards women through the hidden assumptions that caring was women’s work. However, noting the need for feminine values and characteristics within service provision, concepts such as a *family model of care* also supported the normalisation of female *caregiving* for the successful implementation of *community care*. Possibilities for *consultation* were thus shaped by notions of the family as a support network, and a tactic to support the health within the family but with possible restrictions impacting the capability to function as a support.

A Problem of Rights

The last section analysed relations between families being constructed as a support system and the emergence of an associated *burden of care* through that position. The construct of *burden of care* could be examined from a feminist perspective, emphasising the unpaid nature of *caregiving* and the hidden assumption that caring was a female

---

[122] Dalley, G. (1983). Ideologies of care: A feminist contribution to the debate. *Critical Social Policy, 3*(8), 72-81. https://doi.org/10.1177/026101838300300804

[123] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Ministerial Inquiry to the Minister of Health.

[124] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients.* https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

task. The lack of formal service resources and associated responsibility was critiqued by submitters to the MHA, 1987 as having a significant negative impact on the person under services and their family. This section analyses the emergence of rights within *community care*; in particular, tensions arising between *patient's rights* and the rights of family as constructed through notions of 'quality of life' and *burden of care*. Iterations of *consultation* emerge as potential strategies to action rights.

To Care or Not to Care: The (In)visibility of Family Rights

Liberal discourses constructing rights in the space of mental health service provision from the 1980s became more visible in the 1990s. The MHA, 1992, replacing the MHA, 1987, produced 10 rights for *patients* undergoing compulsory assessment and treatment, circulated within a leaflet that could be handed out or attached to walls. The text included "the right to be treated with respect" and a number of actions implying respect, such as being informed of the benefits and side effects of treatments. The production of rights for *patients* within the Act signposted standards of care for those receiving services, enabling the possibility for the notion of family rights to be made visible through a comparable absence. Competing rights between the family and the *patient* arose through responsibility being placed on family as a support network, in both compulsory and non-compulsory mental health service settings, and through a perceived lack of support for this role from service providers. The responsibilisation of the family through *community care*, and the associated *burden of care*, as noted in the Mason Inquiry,[125] provided possibilities for individual and collective critique.

Caregiver support groups provided opportunities for education and support amongst its members, making possible amplified and collective claims for inclusion, speaking rights, and demands for better resources (Trnka & Trundle, 2014). Common arguments circulating by the end of the 1980s and the beginning of the 1990s articulated those constraints arising from a lack of responsibility taken by formal services alongside a new focus on *patient rights*, seen to be limiting family 'quality of life'. The following example from the 'Whangarei Mental Health Caregivers Support Group' typified concerns raised through constructing relations between *mentally ill* persons, their

---

[125] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Ministerial Inquiry to the Minister of Health.

apparent freedom from service oversight, and a resulting dangerousness directly impacting family and the community:

> The “right to be mad” and the “right to refuse treatment” has created chaos and disorder. The LAW fosters insanity! Helpless mentally ill are free to take the Street Treatment – DRUGS and ALCOHOL. Families have the choice of leaving their loved one out in the streets, or becoming a prisoner to madness in their home. Rights of families must be set in statute. No mental patient lives without a grieving family or relative… families must have at LEAST - equal rights. Where patient rights infringe their family’s right to quiet enjoyment of their own lives, homes and relationships, and the rights of public to safety, decency and order, then “civil liberties” for the abnormal should not outweigh those of the family and public.[126]

Protesting against the perceived lack of rights for family through association with *patient rights* in the MHA, 1992, the new Act represented the enablement of the ‘quality of life’ of *patients* to have a significant impact on the ‘quality of life’ of family, and the general safety of the community. In the above text, family, represented as decent, and madness as chaotic and disorderly without oversight, presented a shift from earlier discourses producing indecent homes and vulnerable persons as discussed in the previous chapter. The above text constructed persons experiencing mental illness as fully dependent on family to care; and, through that dependency, a burden and a risk. An imbalance of rights was problematised contextual with family choice: to care or not to care. ‘To care’ represented an enduring commitment to the welfare of a family member, a duty to care that:

> does not necessarily supersede other kinds of ties; care might lie in conflict with the values of neoliberal forms of responsibility, but can also be incorporated alongside practices that employ the logic of choice. (Trnka & Trundle, 2014, p. 144)

Backlash from family to perceived lack of rights citing the potential to refuse the position of *caregiver* threatened the overall strategy of *community care* as a tactic for managing mental illness. In a pamphlet produced and circulated by the umbrella family

---

[126] Whangarei Mental Health Caregivers Support Group. (1994, May 2). Submission 1994 Amendment to the MHA, 1992.

support group in Aotearoa called ‘Caring Communities’, the following question was asked:

> WHAT DO YOU THINK ABOUT the mass dumping of our country’s people who are MENTALLY ILL?
>
> **Families and Relatives** must have the right to choose **not** to offer nursing and accommodation, yet know their precious relative will still be looked after for good (e.g. after parents die). And the right to truthful progress and failure reports, e.g. Mental Health staff should tell them of suicide attempts, escapes, assaults, arrests, and relapses.[127]

In this text, the right of family to know the ‘truth’ of events concerning their relative, whether directly *caregiving* or not, stipulated a right of association for family to be informed of that which was kept ‘hidden’ by services. Tension between the right to ‘care’ but not ‘offer *caregiving*’ acted as a form of resistance through challenging assumptions that community integration of the *mentally ill* would naturally be through integration with the family. Family presented another possibility, another position, in relation to *community care* and caring. The right to ‘care’ but not ‘offer *caregiving*’ spoke of broader tensions between the rights of family by association (not directly *caregiving*) to receive information on their relative, and the rights of persons under services to maintain privacy from family not directly involved in their care.

The Construction of the Problematic Family Through Privacy

Within the terms of references of service provision for acute and semi-acute care, family were positioned in the Mason inquiry[128] according to the imperative of ‘privacy’ as to how, when, and what information should be provided to them. *Consultation*, as a term, appeared in the inquiry’s terms of reference as a right for family to be heard and included in determining treatment options. The notion of being involved in decision-making suggested that family needed to know enough information to be able to make an informed decision.

The construction of *consultation* as a right supported the construction of family into identifiable positions within competing and conflicting discourses (Rose, 1999).

---

[127] Our stand-our Kaupapa (leaflet). (n.d). (circa 1993).

[128] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Ministerial Inquiry to the Minister of Health.

Consultation as a right of family activated, for example, the formalisation of *caregiver* in relations with service provision (and later, law though the *principal caregiver* within the MHA, 1992). The position of *caregiver* and experiential knowledge was, however, subjugated to the clinician and clinical expertise through the potential of exclusion arising from the *patients-right-for-privacy*. The Privacy Act, 1993 and the Human Rights Act, 1993 problematised notions of privacy, confidentially, and access to information that played out in mental health service practices between the person receiving services and their family. Privacy and confidentiality could construct the family as a problem, thus limiting their involvement. The following text, written by a self-identified service user in a submission an amendment of the MHA, 1992, represented family intentions as suspect:

> I do not believe that the patient's family should have the right to apply for assessment. The family's involvement with the person can be too intense that they are often unable to be objective. While informal caregivers have rights, so has the person under the new Human Rights Act, 1993 and sometimes the person needs protection from his/her family.[129]

Family rights to speak and act could, therefore, produce toxicity and enable a form of abuse onto the person diagnosed with an illness. The concept of the safety of the *patient* from family harm was a dominant discourse from previous decades witnessed through the construction and removal of vulnerable children from the family home (see previous chapter). Family members could be represented as subjective in decision-making, with the aim of meeting their own needs, rather than the person receiving persons. A newspaper article in 1994 titled "Family had mum locked up"[130] exampled this thinking, citing a woman's experience of involuntary admission by her son whilst grieving, and which was quickly revoked once a mental health lawyer reviewed the situation. This example validated the notion that family could be coercive and exploitative for their own benefit, hence supporting the need for *patients' rights,* in the context of exploitation by family.

However, the barriers experienced by family to access assessment and treatment and the importance of family involvement through the right to be heard, and for their individual situations to be acknowledged, produced another version of family:

---

[129] Anon. (1994). Submission 1994 Amendment to the MHA, 1992.

[130] Family had mum locked up. (1994, March 8). *The Daily News.*

> Auckland Schizophrenia Fellowship branch staff member Cathy Grebener has a schizophrenic son in the mental health system. She says families want health professionals to value them as partners in treatment and care and to be aware of the profound effects mental illness has on the family unit and individual family members. Families want timely access to services and early intervention followed by treatment with the latest anti-psychotic medication. They also want recognition of the burden of caring for someone with serious mental illness and the support needs, she says.[131]

As articulated within this newspaper article, the notion of *partnership* as a right emerged in the 1990s as a solution to the tensions between caring, burden, and positive outcomes for the person under services. This could be described as a relationship where family accepted biomedically formulated knowledge of mental illness in exchange for the validation of experiential expertise from the positions of family and *caregiving*. *Partnership* was proffered to support the person receiving care and therefore reduce *burden of care*. The possibility for *consultation,* in the form of reciprocal communication, emerged as beneficial for both parties: services could gain early access to the person undergoing treatment through the gaze of the family; the family was heard, and through being valued, receive a timely response, reducing burden. *Partnership,* as a concept and strategy, began appearing in government documents by the turn of the turn of century (discussed below). This provided new iterations for *consultation* as a solution to support better understanding between family and clinicians.

Easing of *burden of care* and involvement in service provision had also been identified within the Mason inquiry as arising from a right to be involved and experience the practice of *consultation*:

> We no longer have dark attics with barred windows where we lock our mentally ill relatives - and thank heavens for that! - but families are torn apart by having a seriously unstable person with a major mental illness in their midst. The stress and distress caused to parents, siblings and also to extended family, is incalculable. Families must be involved in the ongoing planning for the person's future. They must be consulted and take part in the discharge planning, which

---

[131] Mahy, P (1997, October 1). Sharing power with patients. *The Evening Standard, p. 9*

> must begin early enough to enable support systems to be in place for the person with the disability, and if necessary for the family.[132]

The right for family *consultation* in the form of decision-making was represented as historical progression within service provision through better relations between family and clinicians. *Consultation* represented receiving information, engaging in dialogue, and discussing and implementing plans. *Consultation* and involvement in aspects of service provision, such as discharge, represented strategies to increase their agency and power within relations with clinicians.

Resistance Through a Code of Rights

The inquiry and an increasing visibility of family in the media with regard to *burden of care* and poor treatment outcomes spotlighted space for the emergence of formalised family rights. The ‘Schizophrenia Fellowship’ (what was to become ‘Supporting Families New Zealand’), an organisation comprised of the parents of persons diagnosed with mental illness, produced the Code of Family Rights in 1999. Launched by the Health Minister Wyatt Creech, the code was signalled as “a useful tool to help families provide support.”[133]

> The code says families have the right to be treated with understanding and respect, to be taken seriously when they express concerns about changes in someone’s behaviour and to information about a family member’s illness, the diagnosis, treatment and possible side effects of treatment. They also have the right to information about the services and support available for them in the community, to be consulted about a family member’s care and discharge plan and to know the names and contact phone numbers of the family member’s professional caregiving team so they know who to call for help.[134]

The ‘code of family rights’ documented the practices required by services to include family, thus normalising their presence in decision-making. *Consultation* represented family being made aware of specific aspects of treatment and identified those holding responsibility for decision-making. The code thus increased the responsibility of those providing services through making clinicians visible and contactable by family. The

---

[132] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Ministerial Inquiry to the Minister of Health.

[133] Beehive.govt.nz. (1999, March 18). *More awareness of mental health needed*.

[134] Forde, R. (1999, March 10). Code of rights to be launched. *The Evening Standard* (Edition 2), p. 2.

right to be taken ‘seriously’ signalled an acceptance of experiential knowledge as an authority, a form of power sanctioning family involvement.

Section Summary

In this section, my analysis identified that the growing rights of those using services made visible the lack of rights for family. The early 1990s witnessed *patient rights* through law such as the Privacy Act, 1993, the Human Rights Act, 1993, and the MHA, 1992. The late 1980s and 1990s led to the formation of family support and advocacy groups critiquing the lack of family rights in comparison to *patient rights.* The notion ‘to care’ but not provide *caregiving* threatened the concept and strategy of *community care* in its early days, contributing to the emerging relevance and power of family experiences and perspectives in the *community care* space. *Consultation* materialised to promote the sharing of information from clinicians to family, and in other iterations to enable family to have the potential to speak on practices such as discharge planning and have named clinicians to contact. *Consultation* is this iteration continued to privilege clinical processes, providing further possibilities for critique. *Patient’s rights* continued as an entity with the potential to exclude or limit family involvement through construction of the problematic family. However, relations between family and clinicians continued to grow and develop. The notion of *consultation*, appearing in a variety of spaces, including a code of family rights, resisted exclusionary practices.

Consultation represented as information sharing and the potential for family involvement in decision making, including the right not to provide *caregiving*, operated within biomedical discourse. Critique of psychiatric practices enacted through discussions about ‘quality of life’ and *burden of care* operated within, and to a degree actually endorsed, psychiatric discourse. *Consultation* with family emerged as a window into the thinking and functioning of psychiatric discourse for families that nevertheless upheld the authority and *rights* of psychiatry as dominant discourse. The next section provides an analysis of critique that challenged the authority of psychiatry through the construction of Māori knowledge positioning family and whānau expertise in opposition to biomedical discourse.

The Construction of Māori Expertise as Relational

The last section analysed the emergence of several iterations of *consultation* within liberal discourse that focused on the rights of family. The rise of family support groups promoting agency of family and, to some extent, challenging psychiatric practices did so within biomedical discourse that upheld the authority of psychiatry as responsible for caring for persons diagnosed with mental illness. This section shifts to discourses critiquing psychiatric practices and biomedical discourse from the perspective of Māori expertise and leadership within the planning and delivery of services for Māori.

Resisting Western Notions of Expertise

The Mason report detailed several concerns for Māori ranging from the planning and management of service provision, staffing, education and training, and assessment and review processes. A lack of Māori representation and disregard for Māori identity in education, for example, was noted in the report as a barrier for Māori in providing services to enter into the 'profession' of psychiatry. Gaining a Western qualification as a criterion for entering into the profession revealed service provision as monocultural:

> That [gaining a qualification] is proper in terms of Western psychiatry. There are however, many aspects of care in which the training is in Taha Maori, and it is for us to determine the validity of the quality of that training. This training is a lifelong process, which is performed in context of the individual's whanau, hapu, iwi, and with their Kaumatua and Kuia. This qualification is equally as valid as any university degree you may set as criterion, and the people with these qualifications must be incorporated into multidisciplinary psychiatric teams. Only people with this training can provide the quality of care-taha Māori.[135]

Māori expertise, defined through relationships guided by elders (kaumātua and kuia), and occurring through the cultural foundations of whānau, hapū, and iwi, critiqued Western psychiatric training as exclusionary through non-recognition of Te Ao Māori (worldview). According to Mead (2022), Taha Māori represented a Māori perspective, customary in the 1980s to signify the recognition in educational settings that Māori came with Māori culture and thereby their culture needed consideration. Taha Māori was an unclear term, but it led to greater discussion of mātauranga Māori. The notion of mātauranga Māori as a body of knowledge emerging from Polynesian origins and signifying "something essential about the Māori world, something distinctive, valuable" (Royal, 2012, p. 34) provided possible alternatives to practices constructed through psychiatric education.

---

[135] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 178). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

However, Māori culture had been significantly subjugated, a notable example was the Tohunga Suppression Act 1907 where traditional Indigenous healing practices were prohibited, enabling the domination of Western constructs of health (Taitimu et al., 2018). Active resistance to Māori culture and meaningful integration of Te Ao Māori (worldview and cultural practices) subjugated Māori tino rangatiratanga (self-determination) (Levy, 2003) in providing support for persons diagnosed with a mental illness in Western systems. Resistance to the suppression of Māori ways of doing in the 1980s emerged through the notion of whanaungatanga, the cultural value of kinship and connection, seen through nurturing relationships (Greaves et al., 2021),[136] offering an alternative form of expertise:

> There is no way you can convince me that a 19 year old registered nurse has any more clues than these two (refers to kuia) who have raised their families and grandchildren and worked on a limited budget. There must be ways we should be looking at in facilitating their access and working here. These kingdoms, they are hierarchically structured, and they are made to block people out. Our people for years have been working with our people and doing a great job, but of course they come under stress because they are under resourced, and they are doing it for nothing.[137]

The above quote taken from the Mason report captured Māori at Rehua Marae (Canterbury) discussing Sunnyside Hospital, a large psychiatric hospital situated in the South Island of Aotearoa New Zealand. Hierarchical structures within psychiatric practice enabled Western discourses to limit Māori supporting Māori within institutions. The expertise of Māori, developed through the notions of whanaungatanga and mātauranga Māori, continued to be constrained through the legitimisation of Western concepts and strategies as criteria to function within the institution of the hospital. In broader terms, the education system constrained the general involvement of iterations of Māori family and whānau of persons under services through a disregard of different expertise. Stress arising not through intimate relations, but rather a lack of resources (including financial resources), constrained whānau in *caregiving* practices. A situation

---

[136] Whanaungatanga can be defined as an implicit underlying aspect of Māori culture and encompasses shifting definitions to meet the needs of Māori in contemporary times.

[137] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 167). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

arising out of the hierarchal categorisation of what is considered legitimate and resource-worthy knowledge and practices constructed by Western discourses.

Increasing the influence of Te Ao Māori (Māori worldview) to tackle dominant Western discourses was increasingly prominent from the 1980s in the health arena. In a report advocating Māori perspectives, written for the Department of Social Welfare, racism was noted as a barrier to Māori tino rangatiratanga (self-determination) and, in turn, a barrier to the possibilities to take on responsibility that self-determination enables. A fundamental objective summarised in the report concerned notions of superiority and inferiority constructed through discursive practices:

> To attack all forms of cultural racism in New Zealand that result in the values and lifestyle of the dominant group being regarded as superior to those of other groups, especially Maori, by: (a) Providing leadership and programmes which help develop a society in which the values of all groups are of central importance to its enhancement; and (b) Incorporating the values, cultures and beliefs of the Maori people in all policies developed for the future of New Zealand.[138]

Racism, represented as epistemic injustice towards Māori (persons, lifestyle, and values), was noted in the report as constraining Māori cultural practices in institutions. The report argued that the consequences of subjugating Māori culture led to social injustice, deprivation, a lack of personal integrity, and powerlessness. Strategies to tackle the subjugation of Māori included forms of power sharing and equitable sharing of resources within practices of social welfare. Relations witnessed between dominant Western discourses and Te Ao Māori (worldview), for example in education and social welfare, constructed Māori identity and values as sub-standard and thereby marginalised within practices, such as through limiting resources.

The Materialisation of Biculturalism

Constraining Māori knowledge in this fashion acted to limit the ability of family and whānau to provide support and limit their right to speak through positioning Māori concepts such as whānau-led service provision as inferior. Māori identity, including the meaning of whānau and whanaungatanga, had shifted relative to colonisation, land

---

[138] The Māori Perspective Advisory Committee. (1988). *Puao-Te-Atu-Tu (Daybreak). The report of the Ministerial advisory committee on a Māori perspective for the Department of Social Welfare* (p. 9). https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/archive/1988-puaoteatatu.pdf

confiscation, and mass migration to urban areas from the 1950s (Greaves et al., 2021; Metge, 1995). The decline of traditional social systems of support through urbanisation impacted the underlying values that shaped and formed a sense of collective identity, thus diminishing whānau as central to the functioning of family units (Moeke-Pickering, 1996). In relation to the concept of *community care,* Māori whānau experienced a form of prohibition from Western standards, such as educational qualifications and, more broadly, norms of practice based on the authority of Western knowledge. The notion of sharing 'power' provided possibilities for the construction of *biculturalism* in service provision: practices drawing from biomedical and Te Ao Māori (worldview) discourses in collaboration. However, as discussed below, the lack of resources provided for Māori Kaupapa services signalled *bicultural* practices as a construction dominated by Western discourse.

Examples of alternative services run by Māori supporting Māori experiencing mental illness were portrayed in a magazine titled '*Mental Health News*'. Māori Kaupapa (Māori values and principles) provided the possibility for alternative service provision:

> Mary Heihei is the voluntary Kaitiaki/Manger at Te Whare Tiaki, Otara. The Trust is part of a large concern at the Whaiora Marae. There are three flats; she lives in the middle flat and oversees up to five young women and five young men living in the flats on either side of her. All the residents are ex-patients and have various levels of mental wellness. The Kaupapa of this facility is marae-based… Mary has an excellent relationship with the community psychiatric staff attached to Middlemore and Kingseat Hospitals, such as the social workers, psychiatric district nurses and medical staff. Because she does not have a car, Mary says "in an emergency, they will even bring out the necessary medication". Mary has spoken about Maori residential care for psychiatric survivors at various hui and conferences. Always there is the underlying impression of aroha from this reserved woman, working quietly away, for nothing.[139]

In the above text, hapū and iwi within primary support and caring positions challenged the norm of clinical relations between service provider and receiver as paramount, and whānau as a secondary support. Māori Kaupapa services as an alternative to Western models, however, were subjugated through a lack of resources even where reciprocal

---

[139] Prichard, A. (1994). The two Mere. *Mental Health News*, p. 13.

relations of partnership were possible. A lack of resources and financial recognition mirrored the critiques of women as unpaid carers informed by feminist discourses, as with the volunteer kaitiaki/manager role in the above text, and the feminine quality of aroha (love) as the motivation of service provision. Potential for collaboration between Māori and psychiatric services emerged to challenge male dominated clinical expertise and position the absence of whānau involvement concerning Māori *caregiving* as undoable.

Māori Kaupapa influence on family and whānau inclusion therefore offered alternatives to Western constrcuts of service provision including residential care, as it constructed expertise as relational rather than professional. Constructing Māori expertise for Māori through a relational model of care provided the possibility to further validate the expertise and thus the inclusion of non-Western family and whānau in Western service provision, including legal processes. The intersection of Māori Kaupapa services and services driven by Western constructs provided the conditions of possibility for greater collaboration in service actions, including *consultation*, constructed through the notion of whanaungatanga.

Section Summary

In this section, the construction of Māori expertise from a relational model problematised monocultural practices that constrained mātauranga Māori within mental health service delivery. Family and whānau stress, constructed through a lack of resources and the privileging of expertise within Western categories, enabled critique through the notion of cultural racism. Mātauranga Māori and whanaungatanga as notions within health care, supressed through colonisation, emerged to provide alternatives to Western constructs of health and service delivery.

Intersections between Westerns constructs and mātauranga Māori materialised in the form of *bicultural* practices, a construct that acknowledged Western and Māori perspectives. Māori expertise within a relational model of care provided an alternative version of *consultation* through the possibility of cultural mergence in service provision. The notion of *biculturalism* within State sectors emerged through growing recognition and inclusion of Te Ao Māori (worldview). In the next section the emergence of policy and discussion documents in the 1990s provides relations between family responsibility and possibilities to function as a solution within service provision.

Identification of Family Needs Within a Responsibility to Care

In the previous section, the lack of nationwide formal relations between the State and Māori Kaupapa services limited Māori practices to care for Māori through a lack of acknowledgement and resources. Māori expertise in the form of relational working provided alternative possibilities for service provision from whānau. This section analyses the construction of *community care* in policy and supporting documents as the preferred (Western) option for managing mental health service provision, with Te Ao Māori (worldview) absent from initial policy.

Family Responsibility in the 'Truth' of Community Care

In 1994, the government released 'Looking Forward: Strategic Directions for the Mental Health Services' signalling future changes to service provision. Citing previous failures as noted within the Mason Report and unspecified subsequent reviews, the Minister of Health acknowledged

> It is now internationally recognised that community-based care is the best and, ultimately, the most cost-effective way of providing mental health services. The Government is committed to a community-based model for mental health services, backed up by sufficient inpatient services for acute and secure care. The measure of that commitment is the strategic directions set out in this document.[140]

The authority of international practices was used to construct the 'truth' of *community care* as the legitimate strategy to solve the problem of mental health service provision in Aotearoa New Zealand. Employment of cost-effectiveness as critical to achieve best outcomes for *consumers*, embodied the relatively sudden shift from social welfarism to neoliberal thought in the political landscape from the 1980s. *Consumers,* (the terminology used in the report), indicated the conceptualisation of a person diagnosed with mental illness within economic terms, signalling a new position involving choice, and thereby, responsibility for their own *wellbeing* through the procurement of supports.

Empowerment of those using services and their family and whānau as a strategy to decrease prevalence of mental illness and increase the mental health status of the nation signalled shifts of power concerning relations of expertise (Rose, 1999). Services, essentially constrained from taking full accountability, need now only "contribute to the

---

[140] Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services* (p. 3). Author.

best possible outcomes"[141] through acknowledging the expertise of the *consumer* and their family from the lived experience of mental illness. As a significant rupture, the shift from social welfarism to neoliberalism acquainted expertise with responsibility, and the family unit was expected to take on major responsibilities in caring.

> The primary responsibility to care for those in need rests with the family concerned. Families must be encouraged to support and care for their individual members, and be responsible for meeting their needs. Outside assistance is best provided at community level, and in a successful community families and individuals work together to care for the weak and those at risk. If all families and communities functioned in this way, the costs of state-funded welfare would be much reduced.[142]

In this newspaper article, the construction of family as primarily responsible for caring for family members impacted by mental illness is an example of the influence of neoliberal thinking on service provision. Graham Lee, co-leader of the political party Christian Coalition, provided a neoliberal strategy to reduce service costs through promotion of individual (family) and collective (community) responsibility. Constraining State responsibility tendered a morality onto the family (Rose, 1999); they were ultimately responsible for the *weakness* within the unit, and thereby ethically responsible for the solution. Reshaping the family as the rightful entity for *caregiving* emerged through neoliberal thinking, placing new demands on the family within service provision. The authority of psychiatry, whilst left unchallenged as conceptual thought, was challenged in practice through categorising institutional service provision secondary to community-based services, as within the strategy of 'Looking Forward'.[143]

Contrasting Constructions of Family Re-circulated in Policy

The 1990s witnessed the emergence of several strategies problematising family within the position of *caregivers*. The formation of a mental health commission (arising from the Mason report and Mason inquiry and established by the government in 1996 to monitor the implementation of its mental health strategy) aimed to reduce discrimination and strengthen the mental health workforce, including strategies

---

[141] Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services* (p. 5). Author.

[142] Party leaders answer your questions. (1996, August 21). *Press*, p. 12

[143] Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services*. Author.

involving family. ‘Blueprint for Mental Health Services in New Zealand: How Things Need to Be’ (‘Blueprint’) contained contrasting discourses on family and whānau. Family and whānau, mirroring discourse of the 1950s to 1970s, were constructed as unhelpful through aggravating illness but also a possible strength:

> Whanau (family) stress can exacerbate illness and thereby increase the need for services for tangata whaiora (people seeking wellness). Identification and response to whanau need will lessen the impact of whanau disturbance on tangata whaiora, and lessen the need for services. Whanau strength can buffer the impact of illness on tangata whaiora, and thus lessen the need for services.[144]

Identification of family needs promoted the activities of examination and confession and possibilities for shaping the conduct of family into desired positions of *caregiving* from within psychiatric discourse (Foucault, 1977, 1978). The home, constructed as a clinic, performed an expansion of the practices of psychiatry, with *community care* normalising family as *caregiver* through a notion of expertise. Constructed as a strength advantageous for services by lessening their requirement for input, family became a possibility for engaging in practices that met service values. As experts, with potential for more expertise, education could target specific practices such as monitoring symptoms and informing services of change within a right to speak. The ‘Blueprint’, in noting the need for family and whānau inclusion, authorised clinicians to identify family needs and shape family conduct within psychiatric discourse (Foucault, 1977).

> Interventions that only include the individual with mental illness are making only a partial response and therefore can only ever be partially effective. Fully effective interventions acknowledge and assess the needs of everyone affected by the illness. Family-inclusive mental health services should:
>
> – pay attention to the emotional, educational, social, and clinical needs of the whole family
>
> – assess the strengths, problems, and goals of the person with a mental illness and key family members
>
> – formulate a plan that co-ordinates all elements of a person’s treatment and support (including medication) so that all involved, inside and outside the

---

[144] Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be* (p. 10). Author.

> family, are working towards the same goals in a collaborative and supportive relationship, and the family is provided with the skills and strategies required to cope with the illness, to facilitate recovery, and to maintain good relationships within the family
>
> – provide the person with a mental illness and key family members with information about the illness and its treatment.[145]

The above text noted that services, now fashioned as *family-inclusive mental health services,* constructed family as impacted by mental illness and essential for service provision to be effectual. Examination of the family unit, regarding their 'needs', supported the identification of factors influencing the functioning of illness on the family unit, and requirement for interventions. Emotional responses, such as distress or the development of illness for *carers,* were identified as *burden of caring* and enabled positions for direct clinical interventions on family members, blurring positions of *service user* and *carer*.

Burden of care was instead used to construct family as sick from caring, a shift away from the general stressors arising from intimate relations within the developmental cycle of life, as analysed in the previous chapter. However, the shift to *burden of care* continued to enable the examination of family and justify their inclusion in practices that specifically targeted family. Educational needs, categorised through a psychiatric gaze, signified family as lacking knowledge of psychiatric discourse on a continuum, determining the types of education required. Blurring the positions of *caregivers* with *service users* provided authority for psychiatric practices to act on the family (as also witnessed in previous decades), but it also effected the expertise of family. Within psychiatric discourse, family positioned as experts through lived experience demonstrated a lack of expertise in caring, such as managing the *burden of care*. The above text signalled the expertise of family as subjugated within relations to psychiatric knowledge.

Providing family with information became a model for inclusive service provision, within the tensions between family and *patient* rights, discussed earlier in this chapter. Psychiatric knowledge in the form of diagnosis, symptoms, risks, and monitoring, as examples, provided possibilities of services available to a *consumer* of mental health

---

[145] Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be* (pp. 9-10). Author.

services. As noted in the above text written by the Mental Health Commission, family could support the interventions provided by services if informed and educated on the things required to support the functioning of the family unit. Relations between pastoral and disciplinary power translated service values concerning responsibility through clinicians, shaping the conduct of family and ultimately their family member to enhance health through the neoliberal value of self-investment (Rose, 1999). Translation of the productive values of psychiatry effectuated family as individual role models for the person receiving services (Foucault, 1994h). Managing *burden of care*, through the integration of psychiatric discourse into the practices of family, evidenced the 'truth' of psychiatric knowledge in relations with good health and recovery from mental illness.

Section Summary

In this section, my analysis identified that the introduction of government policy categorised *community care* as the dominant strategy to mental health service provision, with inpatient services as secondary when required. The 'truth' of *community care,* erected through relations with international practices and neoliberal thinking, provided formalised possibilities for disciplining the family into *caregiver* positions. However, family were also constructed as sick (through *burden of care*) and/or detrimental to the *wellbeing* of the *service user* through exacerbating stress in the family unit, a continuation of discourses discussed in the previous chapter. With family now constructed into positions of both sick and *caregiver*, services continued psychiatric practices of treating family but with possibilities for translating psychiatric knowledge through family onto their relative.

Education was a key tactic to promote *wellbeing* within the family unit, requiring the continuation of examination, hierarchal judgement, and disciplinary techniques. Tactics favourable to the aims of psychiatry required the identification of needs, and thus detection of any barriers limiting interventions. Family emerged, through relations with responsibility and expertise from the lived experience, as a potential solution to reduce service input and costs. Moreover, they emerged with tactics to self-enhance the family unit through investment originating from psychiatric and clinical discourses, befitting neoliberal ideals. Possibilities for greater inclusion of family led to possibilities for greater involvement in service provision, a formalised representation of *partner,* and a potential condition for *consultation* as discussed in the following section.

The Construction of Partnership as a Working Relationship

In the last section, *community care* policy and supporting documents provided opportunities to educate and treat family through shaping their inclusion as rightful and, thus, responsible *caregivers*. Interventions for family supported the translation of psychiatric knowledge onto the family and through them onto their family member. This final chapter section analyses growing inclusion and involvement of family in specific practices, normalised and circulated through concepts and strategies such as *partnership* and *working relationships*; enabling further possibilities for shaping family and clinicians. Notions of *partnership* emerged at the end of the 20th century and became dominant within 21st century discourse, functioning to integrate family into a range of practices. These notions are explicated further in the next chapter. This section ends with the emergence of *consultation* in law as a discursive paradox.

Partnership as a Euphemism of Responsibility

Drawing from material in the 'Blueprint' by the Mental Health Commission and citing research from the World Schizophrenia Fellowship promoting family inclusion as its justification, the Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists published guidance notes in 2000 entitled 'Involving Families: Guidance Notes'. Within my research, 'Involving Families' is considered noteworthy text as it constructed inclusion as *working relations* between family and clinicians in *partnership* to improve outcomes in mental health service delivery. This was a significant shift of position for family and whānau, reflecting growing possibilities of involvement in processes:

> Many families wish to be involved in assisting the recovery of their family member. They want mental health staff to work in ways that are inclusive of families. This means that mental health staff need to work with the family and tangata whai ora – sharing information, planning, decision making, and providing support and education when necessary. Whānau want mental health staff to recognise the important principle of whanāungatanga when working with tangata whai ora. Whanāungatanga is about the interconnectedness and interdependence of all members of the whānau, including the tangata whai ora. Whānau health is intrinsic to the health of each member and the health of each member is integral to the health of the whānau. Mental health staff who are operating within this principle contribute their expertise to the strengths,

> knowledge and skills from working in partnership with the whānau rather than treating tangata whai ora in isolation or making decisions for tangata whai ora and the whānau. It is often observed that if mental health services develop effective ways of working with whānau, they will also work effectively with other families.[146]

Positioning family as desirous to assist the *recovery*[147] of the person receiving services provided another layer of justification for services to provide greater opportunities for family inclusion in practices. The notion of guidance in the report, as opposed to mandatory actions, provided iterations for family inclusion, as historical classifications problematising family (discussed in this and the previous chapter) constructed varying needs and capacity to care; therefore, enabling differing relationships and interventions. The promotion of closer working relations with family also constructed clinicians as *partners* within *working relationships*, and signified a subtle form of panoptic governance through clinical self-regulation and self-knowledge (Foucault, 1977; Rose, 1999) to validate the notion of family involvement within the potentially unsupervised spaces of 'community'.

Partnership and *working relations*, in the above text, were presented contextual to Te Ao Māori (worldview) and a relational model of working. The concept of whanāungatanga[148] as tikanga (Māori customary practices), presented as norms for working with any family including non-Māori, signified the emergence of government recognition and acceptance of Te Ao Māori (worldview) within biomedical and psychiatric discourse. The notion of drawing from Māori culture as a norm within service provision was a significant shift from the negative representation of Māori practices from within a European gaze, decades earlier (see previous chapter). The concept and strategy of *partnership* signalled potential relations between Māori and European ways of thinking and doing in service provision, enabling possibilities for greater recognition of extended family systems in practices. *Partnership* signalled the portrayal of choice and tino rangatiratanga (self-determinism) as a euphemism of responsibility within and accountable to standards established within biomedical

---

[146] Ministry of Health. (2000). *Involving families: Guidance notes* (p. 1). Author.

[147] Recovery, as a concept, is discussed in detail in the next chapter, as the inclusion of recovery in service provision from the turn of the century enabled new subject positions for family.

[148] Its use in this text suggests forming and strengthening relations between people.

discourse. Signalling the need for effective relations, *partnership* entailed identifying and fixing potential constraints:

> Understanding the membership of a whānau needs to take account of the subtleties of whānau and their different traditional and contemporary 'definitions'. Working effectively with whānau in care, assessment and treatment processes means working with tapu and whakapapa. The whānau may need to disclose information that may be thought of as whānau 'secrets'. The whānau needs to feel safe before this can occur.[149]

Whānau secrets 'othered' Māori extended family systems as a possible limitation to effective *working relations* between family and clinical staff, recirculating European anthropological discourse critiquing non-Western family practices as potentially deviant (see the previous chapter). 'Othering' Māori signalled possibilities for training and workforce development to increase the cultural knowledge of clinicians through concepts such as cultural safety and Kaupapa Māori practices. Utilisation of Te Ao Māori (worldview) concepts, however, promoted greater Māori family inclusion and responsibilities on clinicians to understand Māori concepts. Training and workforce development emerged as dominant strategies at the end of the 1990s to shape clinicians into *partners*; promoting concepts of family education in relations with 'new' concepts such as cultural safety.

The Paradox of Partnership: To Consult or Not Consult

As an overarching strategy of *community care*, micro-relations between family and clinicians were promoted within 'Involving Families'.[150] Drawing from earlier reports, including the Mason report and Mason inquiry, enabled tactics enhancing relations between family and clinicians were outlined through the generation of specific clinical positions. For example, the *keyworker role*, suggested as early as 1988 in the Mason report, specifically to support continuity in care within forensic and community care settings, provided an early iteration of *consultation*:

> The key worker will be responsible for the primary care and planning of treatment programmes incorporating members of the multidisciplinary team, the patient and family, and any other community members it is seen fit to include. It

---

[149] Ministry of Health. (2000). *Involving families: Guidance notes* (p. 6). Author.

[150] Ministry of Health. (2000). *Involving families: Guidance notes*. Author.

> will be a requirement that the key worker consult with the family and community members where appropriate.[151]

An early iteration of *consultation* in the Mason report signalled the construction of the *keyworker* as a focal point of contact with family. In the above text, the *keyworker* was noted as responsible for planning treatments and could decide if it was ‘appropriate’ or not to consult with family based on the clinician’s construction of the family, *case-by-case*. This notion was reproduced and circulated within policy, supporting documents from agencies such as the Mental Health Commission from within submissions to amendments to the Act, and within Section 7A of the MHA, 1992 in its first and every consecutive version. In a similar vein to the *keyworker,* the *responsible clinician* within the MHA, 1992 emerged as the principal decision-maker concerning *consultation*, when it materialised in 1999. With power held by the responsible clinician, *consultation* as a practice enabled the inclusion or exclusion of family and whānau, a paradox when thinking about the notion of *partnership*. As *consultation* materialised in Section 7A through the 1999 amendment of the MHA, 1992, another paradox emerged:

> “(2) A practitioner must consult the family or whanau of the proposed patient or patient. This subsection is subject to subsection (3).
>
> “(3) Subsection (2) does not apply if the practitioner has reasonable grounds for deciding that consultation -
>
> “(a) Is not reasonably practicable; or
>
> “(b) Is not in the best interests of the proposed patient or patient.[152]

Paradoxical tensions producing *consultation* as a statutory action, as it emerged in the MHA, 1992, was seen through the potential dilemma of the responsible clinician who ‘must consult’ in context with the notions of ‘reasonably practicable’ and ‘in the best interests of the patient’. Paradox can be described as:

> Contradictory yet interrelated elements that exist simultaneously and persist over time. This definition highlights two components of paradox: (1) underlying tensions—that is, elements that seem logical individually but inconsistent and

---

[151] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients* (p. 157). https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

[152] No. 140 Mental Health (Compulsory Assessment and Treatment) Amendment, 1992.

> even absurd when juxtaposed—and (2) responses that embrace tensions simultaneously. (Smith & Lewis, 2011, p. 382)

Consultation, therefore, emerged in the MHA, 1992 as statutory guidance and not a mandatory action for the responsible clinician to consult with family regarding decisions to continue or discontinue actions under the Act, including the possibility for compulsory treatment and hospitalisation. Tensions emerging from *patient rights* in relations with privacy and risks (if concerns about the safety of the person from their family existed), produced a paradoxical *consultation* to enable inclusion or exclusion within the relation of *partnership* with family. With family constructed as responsible for care within the notion of *family-inclusive mental health services*, but also constructed as problematic (sick, stigmatising, generating illness, see previous chapter), the possibility for paradoxical tensions to exclude family in *family-inclusive mental health services* materialised.

Section Summary

In this section, I argued that the concept of *partnership* emerged as a strategy for improving service outcomes which supported the validation of family involvement in *community care* practices. Relations between Te Ao Māori (worldview) and *partnership* also emerged from the notion of *bicultural* practices, providing possibilities for workforce training and development to be ‘culturally safe’. An early iteration of *consultation* contextual to the construction of *keyworker* position was explored to analyse the notion of ‘appropriateness’ in including family and whānau, maintaining clinical power in decision making within the concepts of *partnership* and *consultation* as it emerged in the MHA, 1992 as a statutory practice. In this sense, I argue that *consultation* was paradoxical, drawing from historical discourses such as *risks*, privacy and rights, stigma, and the notion of the problematic family to include or exclude family and whānau as *partners*. The notion of decision-making in statutory practices of *consultation* was introduced to signify the amorphous nature of *consultation*; a notion for discussion in the next chapter.

Chapter Summary

This second chapter of analysis identified intersections between responsibility, rights, and the notion of alternate expertise as key discourses enabling family inclusion in service provision through positions other than being ‘sick’. The absence of policy guiding the initial practices of *community care* and questions concerning responsibility in the Mason report and the MHA, 1987, provided spaces for the emergence of familial expertise. The right to speak enabled the visibility of *burden of care* discourse, subsequently constructed as another iteration of being sick; however, it also made visible the lack of rights of family contextual to the emergence of *patients' rights*.

Feminist and carer discourse critiquing the normalisation of *caregiving* as the family role potentially threatened the ethos of *community care* through highlighting the lack of a right to speak and lack of resources supporting family in *caregiving.* Critique from Māori on the notion of expertise constructed through a Western psychiatric gaze provided iterations of an ‘alliance’ between Te Ao Māori (worldview) and biomedical discourse through the notion of *biculturalism* in State sector services, and an alternate version of *consultation*. However, the emergence of policy and supporting documents for *community care* in the 1990s acknowledged and integrated aspects of Te Ao Māori (worldview) in subjugated positions to Western discourse. Responsibilisation of the family into *caregiving* positions, influenced by neoliberal discourse, and acknowledgment of the need for resources and education for family, enabled the construction of *partnership* and *working relationships* to shape and discipline family and clinicians contextual to growing standards within service provision. Finally, in this chapter, I identified that the intersection of discourses such as responsibility, *risks*, and rights, in context with historical categorisation of family as problematic constructed *consultation* as a statutory practice within the MHA, 1992, and a discursive paradox constraining *consultation* within psychiatric discourse as a practice.

The next chapter provides an analysis of contemporary text from 2017 to the time of writing, a time when the latest national inquiry (Paterson et al., 2018) called for the repeal and replacement of the MHA, 1992, generating the possibility for a new rupture in the care and treatment of persons diagnosed with a significant mental illness, and ‘new’ positions for family and whānau *consultation*.

Chapter Seven: Constructions of Family and Whānau in the 21st Century (2017–2024)

Introduction

In the previous chapter, analysis of the mid-1980s to the turn of the century identified responsibility, *risks*, rights, and familial expertise as discourses enabling possibilities for family and whānau inclusion and *consultation* in mental health service provision. The emergence of policy (Ministry of Health, 1994, 1997) and guiding documents, such as the 'Blueprint' (Mental Health Commission, 1998), formalised and normalised *community care* discourse, supporting the construction of family and whānau as *caregivers* and *partners* within government guidelines. Increasing visibility of Te Ao Māori (worldview) provided critique on services as monocultural, and possibilities for alternate version of *consultation*, within greater acknowledgment of the dominance of Western discourses. *Consultation* emerged as Section 7A within the MHA, 1992 as a contested discursive practice; a necessity and a choice for clinicians to consult with family and whānau as *partners* during compulsory assessment processes.

This chapter focuses on texts from the last 5-years (2017-2023). 'He Ara Oranga: The national inquiry into mental health and addictions' (Paterson et al., 2018), is noted as a key text in my analysis, as it provided comprehensive critique on mental health service provision at a national level; the first national review since the Mason et al. (1996) inquiry. It is also noted as significant as the report recommended the repeal and replacement of the MHA, 1992; hence, offering the possibility of a new rupture in the delivery of compulsory assessment and treatment and new possibilities for family and whānau *consultation*. Although the focus on analysis is from within the last 5-years (at the time of writing), earlier texts are also included for analysis through providing context and background. Incorporating a chapter on contemporary discourse in this thesis enables analysis of constraints and possibilities in present practices arising from historical discourses, and thereby where future practices have the potential to be otherwise (Fadyl et al., 2013b).

The focus of this chapter concerns the problematisation of the MHA, 1992 through the national inquiry 'He Ara Oranga' (Paterson et al., 2018), and the implications that this may have for family and whānau and practices of *consultation*. Major critique within the report was on how practices arising from the Act are strongly shaped by relations between mental disorder and *risks*, dominant discourse seen within practices of *community care*, and historical institutionalisation surfacing through legal processes. The mental health Acts of New Zealand have continually sought to identify *risks* alongside mental disorder to justify incarceration or other forms of coercive practices, such as restraint and seclusion.

Practices of forced hospitalisation and treatments, seclusion, and restraint associate mental illness with 'dangerousness', and the WHO and United Nations (2023) have suggested that this sustains stigmatizing and discriminatory practices. These practices have been increasingly problematised as human rights abuse with specific concerns focusing on the notion of *equity* in Aotearoa. In my analysis of 'He Ara Oranga' (Paterson et al., 2018) and other contemporary texts, notions of resistance have emerged that challenge dominant psychiatric discourse shaping mental health service provision through relations between mental disorder and *risks*. *Recovery*, *equity*, and *wellbeing*, are explored in this chapter to demonstrate possibilities of resistance to negative constructions of *risk*, and thereby other options for family and whānau *consultation* practices.

This chapter's content is, therefore, presented slightly differently to the last two chapters of analysis. This final analysis chapter contains four 'mini-chapters' focused on distinct discursive constructs: *risks*, *recovery*, *equity*, and *wellbeing*. Each mini-chapter outlines the current function of the construct within contemporary discourse and its historical emergence in policy or practices. The first mini-chapter begins with a brief discussion on negative and positive constructions of *risks* contextual to mental health service provision. These constructions of *risks* historically constrained family involvement during the era of institutionalisation and, more recently, provided possibilities for greater family involvement through *community care*. The second mini-chapter explores resistance to *risks* through the emergence of personal and clinical *recovery* and its contemporary shift to incorporate community. *Recovery* is analysed in policy and research as a strategy enabling greater involvement of family and whānau through shifting notions of inclusion from individuals to family and whānau, and finally onto society through the notion of community. The third mini-chapter provides an analysis on the emergence of *equity* critiquing the MHA, 1992. The construct of *equity* is explored through the problematisation of health disparities, and through the concept and strategy of 'Whānau Ora' to reduce disparities and resist dominant Western psychiatric discourse in mental health service provision. In the final mini-chapter, *wellbeing* is analysed as a concept that broadens definitions of health through the model of Te Whare

Tapa Whā, and the implications of *wellbeing* arising for family and whānau as a solution within mental health service provision.

The texts analysed to produce the findings for this chapter could be classified into four categories: texts that guide and regulate practices (e.g., policy and guidelines); legislation; articles from research and media; and articles and letters appearing in publicly available publications that document experiences and practices. For this chapter, submissions from family and whānau, those using services, members of the public, and organisations in 'He Ara Oranga' (Paterson et al., 2018) were taken from a summary document of the 5,000 plus submissions received by the Inquiry Panel. Although data selected by the panel for the purposes of summary are a possible limitation of texts available for analysis, the breadth of submissions presented in the document still provided copious data to identify and analyse dominant and less dominant discourses.

Constructions of Negative and Positive Risk

Defining the construct of *risk* is complex when applied to diverse practices and from different perspectives. *Risk*, signifying the possibility of harm or danger (Cambridge Dictionary, 2023), can appear in texts to contemplate uncertainty and provide a function within practices (Holton, 2004). The MHA, 1992 is an example of a text that uses *risk* in association with *mental disorder* to enable specific practices to occur, such as compulsory assessment and treatment practices that enable actions to be taken on persons. Politically, notions of *risk* and *risk management* can shape how societies function through constraining and limiting activities, the allocation of resources, and the dispersal of political power within society (Fischhoff et al., 2013). *Risk* discourses fit well with Foucault's (1994h) notion of political and scientific technologies governing populations through regulatory actions derived from power/knowledge.

In relation to my thesis, notions of *risk* have been (re)produced from family and whānau, clinicians and service providers, media, research, critique (from reviews), Acts, and policy. In Chapter Five, I identified a notion of *risk* emerging in practices where children were removed from family through relations of vulnerability and parental deviance to prevent the potential socialisation of deviance, including mental illness. In Chapter Six, I argued that *risks*, in relations with notions of responsibility and accountability, were crucial to the legitimacy of the critique constructed in the Mason report[153] problematising *community care* practices. *Risks*, as constructed from political and clinical positions has generated *community care* practices as a 'safer' alternative to hospitalisation through notions, such as managing risks in the community. The subjectification of persons classified as '*risky*' has provided opportunities for disciplinary practices through shaping present day actions on persons through calculating the potential of future consequences (Rose, 1999). The position of *mental health patient,* as an example, includes construction through documents that detail historical *risk* events, *risk* formulations, and *risk management* plans. *Risks* acts to define persons and can function to limit and constrain freedoms, such as through compulsory treatment, within services shaped through institutional *risk* procedures, policy, and law. This notion is explicated further in Chapter Eight.

Mental health legislation dating back to the Lunatics Act 1846, have employed *risks* as strategies to justify actions when responsibility has been called for, enabling the movement of persons from or to the community. Typically, movement has signified incarceration; however, the MHA, 1969 enabled the movement of persons previously incarcerated into community residential homes, as noted in Chapter Six. In the 'Guidelines to the MHA, 1992',[154] *risk* was represented in a variety of discourses, constructed to achieve specific aims, such as reduce harmful behaviours and attempts to escape, and represent rights as in receiving culturally appropriate services. *Risk factors, risk assessment*, and *risk formulation*, as concepts, act as strategies authorising practices ranging from seclusion and restraint, to notions such as informed consent and involvement of family and whānau (Matthewson, 2002; Slade, 2010). In a general sense, *risks* contextual to historical and contemporary mental health service provision have been constructed in negative terms with practices focused on managing *risk* through reduction and elimination of unwanted behaviours.

Resistance to discourses of *risk* materialised in the 21st century within policy and guidelines in Aotearoa New Zealand. 'Building on Strengths',[155] cited as a new

---

[153] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients*. https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

[154] Ministry of Health. (2022a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

[155] Ministry of Health. (2002). *Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa*. Author.

approach to promoting mental health, problematised notions of *risk prevention* versus health promotion.

> There is a tension created by the inherent differences between prevention (with its emphasis on risk factors) and health promotion (with its emphasis on quality of life and potential for positive mental health). *Building on Strengths* promotes actions that are focused on developing both individual and community resilience as well as paying attention to mental health protective factors.[156]

Recirculating knowledge from the 1950s on promoting mental health, as opposed to preventing mental illness,[157] the above text employed constructs of 'quality of life' and 'positive mental health' to build resilience to factors causing mental illness. Population health discourse employed the notion of resilience as a mechanism for responding to adverse factors and situations, enabling the construction of categories of behaviours to avoid or situations to pay attention to. In the report, *risk factors* arising from family included a range of possible experiences; from being a single parent to a large family; to the experiences of childhood neglect; and to harsh and inconsistent discipline style. Categories of individual, family, and community factors, life events, the context of schooling and culture, constructed associations between deviant behaviours and illness development. The emphasis on health promotion in the report enabled greater visibility of *risks* in life contexts through notions such as 'protective factors' and resilience. Even within a document problematising its dominance, *risks* emerged as dominant within the notion of health promotion.

Relations between the notion of positive mental health and *risks* also materialised in a different sense through the concept of *positive risk-taking*. *Positive risk* (also known as therapeutic risk-taking), was constructed in research through the notion that considered *risk-taking* as supporting *recovery* and growth (cf. Reddington, 2017; Robertson & Collinson, 2011). As a strategy enabling autonomy of the person receiving services, *positive risk-taking* interrogated *risks* contextual to responsibility in association with an individual's rights and the obligation of services.

> A strengths-based approach would support a recovery model. A person's strengths are vital resources for recovery, particularly for their self-management

---

[156] Ministry of Health. (2002). *Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa* (p. 20). Author.

[157] World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health.* Author.

> of risk. Identifying strengths is also important to support positive risk-taking. This also may include the strengths within the person's family/whānau and wider support networks. Clinicians will often decide whether to support someone to take positive risks based on the information available to them. For example, if that information is a risk assessment of deficits and failings, then the answer may be different than if the assessment takes a strengths-based approach.[158]

In this text from a discussion paper, 'He Arotake ngā Tūraru. Reviewing risk: A discussion paper', positive *risk* intersects with a strengths-based approach to practice and the concept of self-management of *risks* to engage in *recovery*. *Risk*, in this sense, was constructed as a technique to enable a better self-understanding of the experience of mental illness and possibilities for changing conduct from within, a technology to constitute the self as *recovery-focused*. Although self-management indicates the individual, a collective approach can be taken, thus involving others, such as family and whānau. Foucault (1994i) noted how specific technologies (techniques) of governance provided the conditions for people to constitute themselves:

> Technologies of the self… permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to obtain a certain state of happiness, purity, wisdom, perfection, or immortality. (p. 225)

The continued promotion of association between strengths-based and *positive risk-taking* within practices in 'He Arotake ngā Tūraru'[159] makes visible constraints from service providers within tensions between negative constructions of *risk* associated with harm and *positive risk-taking.* The notion of creating the *service user* as an 'experiencer' of *recovery* provides possibilities to constitute clinicians and the family into *facilitators of recovery* (discussed below in the mini-chapter on recovery). Inclusion of family and whānau, in the above text from 'He Arotake ngā Tūraru', provided space for family to enable *positive risk-taking* from the position of support system. Within this position, constitution of the family as a *facilitator of recovery* provides an environment for *positive risk-taking*, furthering the construction of relations between *positive risk-taking*

---

[158] Ministry of Health. (2022). *He arotake ngā tūraru. Reviewing risk: A discussion paper* (p. 33). Author.

[159] Ministry of Health. (2022). *He arotake ngā tūraru. Reviewing risk: A discussion paper*. Author.

and *recovery* as an appropriate rule underlying mental health service provision within the community.

The notion of *recovery* has become a dominant discourse in New Zealand guidelines and policy, emerging in texts from the 1990s.[160,161,162,163] It was also noted in 'He Ara Oranga'[164] as a desirable aim achievable through improvements in mental health service provision. Acknowledging that it is a dominant discourse, shifting representations of *recovery* are explored (below) as strategies that enabled persons under services, family and whānau, and community to be involved and hold agency in institutional and *community-care* practices. I argue that greater involvement and agency through *recovery* has implications for family and whānau *consultation*, with shifts in practices away from managing negative constructions of *risk* in future mental health legal processes.

Summary

In this mini-chapter, early iterations of *risk* focused on dangerousness, a dominant discourse that has shaped mental health practices for the past 200-years within the asylums, large psychiatric hospitals, and within the community. As a political tool, negative constructions of *risk* have been used to govern populations through the notion of *managing risk*, enabling practices such as compulsory assessment and treatment, hospitalisation, seclusion and restraint. In this sense, *risks* have significantly shaped the emergence of *consultation* within the 1999 amendment of the MHA, 1992 through a focus on managing *risks*. Within the transition from institutional to community-based care, *risks* were problematised in association with responsibility, as discussed in the previous chapter, enabling the dominance of *risk* discourses within the MHA, 1987 and the MHA, 1992. Resistance to *risks* materialised in government policy at the start of the 21st century, with the notions of a strengths-based focus to service provision and therapeutic/*positive risk-taking*. Contemporary discussions[165] from government constructing *positive risk* as facilitating *recovery*, provided spaces for family and

---

[160] Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be.* Author.

[161] Mental Health Commission. (2012). *Blueprint II: Improving mental health and wellbeing for all New Zealanders. How things need to be' (Blueprint II)*. Author.

[162] Minister of Health. (2006). *Te kōkiri: The mental health and addiction action plan 2006–2015.* Author.

[163] Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Author.

[164] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health

[165] Ministry of Health. (2022). *He arotake ngā tūraru. Reviewing risk: A discussion paper*. Author.

whānau involvement through contemporary notions of *recovery*, as explored below, and the possibilities for shaping future practices of *consultation*.

The Emergence and Co-option of *Recovery*

In 2016, in response to announced cuts to mental health funding by the government, a campaign by Actionstation, a crowdfunded community organisation, invited feedback from people on their encounters with mental health services. In the following year, the 'People's Mental Health Report'[166] published stories from this campaign, noting that 93% of submissions focused on problematic service access, summarised as a "lack of respect, dignity, choice and control". Calling for an urgent inquiry into mental health services, Actionstation's campaign continued the problematisation of mental health service provision in the community and within the hospital through agency of those experiencing[167] service provision. Family and whānau were constructed into two main positions in the report: causing mental illness through family violence (recirculating positions discussed in Chapter Five); and as a support system that could facilitate or constrain *recovery*. Family was thus depicted as negative and positive influencers on health. The following quote was from a submitter within the report identifying family as a support:

> My positive outcomes are about the support that I received right from when I was first diagnosed. My family's expectations about who I was and what I was capable of never changed. Their perspective was that given the impact of my illness I'd just need a bit more support to realise my dreams and aspirations. People need to know that recovery is not only possible, it is probable, but it is dependent on the right attitudes and the right support.[168]

The notion of family as a support system in the above text reproduces the neoliberal conception of responsibility discussed in the previous chapter, although with emphasis on family influencing *recovery*. Although *recovery* as a notion developed by the *service user movement* occurred during the 1970s and 1980s, its integration in Aotearoa New Zealand did not dominate service provision until the turn of the 21st century. My analysis has identified *recovery* as a dominant discourse in mental health service

---

[166] Elliott, M. (2017). *People's mental health report* (p. 3). Actionstation.

[167] Experiencing includes inability to access services.

[168] Elliot, M. (2017). The people's mental health report (p. 23). Actionstation.

provision generating positions for family and whānau and providing possibilities for iterations of *consultation*.

In Aotearoa New Zealand, by 2017, discourses relating to mental health service provision had constructed family and whānau as experts from the lived experience of being family and whānau. A document citing mandatory inclusion of family and whānau in mental health services written by the Ministry of Health in 2009, and amended in 2017, drew from notions of expertise and *partnership* to position family and whānau as an objective in the delivery of secondary mental health service provision:

> Families and whānau can play a crucial role in recovery. The recovery process should be viewed as a partnership between the Service, Service User and family and whānau. This relationship should be based on mutual respect for the value and experience that each person brings. Active involvement and communication should occur at all stages.[169]

Relations between family and whānau, the person using services, and service providers, constructed as mutually beneficial for *recovery* to occur, offered the notion of equal *partnership* in power/knowledge arising from within each position. The *recovery process*, situated as a concept and overarching strategy of mental health service provision from the turn of the century, was co-opted into an approach for services through language concerning empowerment, hope, and social inclusion, as examples. *Recovery* as it emerged in the 1970s as a form of philosophy, and later, approach to service provision, provided a framework for those using and providing services in Aotearoa New Zealand from the turn of the century.

The Construction of Recovery as a Way of Life and a Service Objective

Recovery philosophy as critique of the perceived oppressive power of psychiatry emerged in the United Kingdom and USA[170] during the 1970s from persons using services, most often from those experiencing compulsory hospitalisation. *Recovery* emerged through relations with rehabilitation as personal narrative, with individuals citing ideas of active citizenship and social justice merging into small and then larger collectives. Described in general as the *service user movement,* personal agency was structured as a movement for change (Adame & Knudson, 2007; Crossley, 2004). In

---

[169] Ministry of Health. (2017). *Family and whanau services: Mental health and addiction Services – Tier two service specification.* Author.

[170] And in some other European countries to differing degrees.

concurrence with anti-psychiatry discourse (introduced in Chapter Five), the personal narratives of persons within mental health services highlighted their objectification and marginalisation by psychiatry through the functions of diagnosis, labelling, and coercive treatments.[171,172] The following quote from Patricia Deegan, a leading member of the network, was a typical challenge to psychiatry on dehumanisation from diagnosis:

> We are here to witness that people who have been diagnosed with a mental illness are not things, are not objects to be acted upon.[173]

From a personal perspective, *recovery* was constructed as a paradox by Deegan as "personal limitations are the ground from which spring… unique opportunities… a process. It is a way of life".[174] The limitations placed on people from mental illness was equated with the constraints generated by psychiatry. By constructing *recovery* as a way of life, Deegan, and those associated with the *service user movement*, contested 'othering' and sanctioned mental illness as enabling possibilities for human growth and development. The movement endorsed greater power for those experiencing madness[175] and mental health service provision. However, tensions existed between those promoting the notion of *recovery* and those providing services when it came to attempts to circulate *recovery* within service provision.

In Aotearoa New Zealand, 'Psychiatric Survivors' was formed in the 1980s by Mary O'Hagan as part of the international *service user movement*. The below text, taken from her experiences, demonstrated the tensions arising from *recovery's* critique of psychiatry and its integration into service provision:

> We were a small minority, a new stakeholder… we survivors felt as though we were drowning in their entrenched conservatism and patronising attitudes. When we did get to express our views, we soon felt submerged again by the powerful voice of the status quo. The professionals at these meetings pronounced their

---

[171] Deegan, P. E. (1991). *Recovery, rehabilitation and the conspiracy of hope*. Keynote address at The Northeast Regional Training Institute and Conference on Housing Supports, Burlington, VT.

[172] Leete, E. (1989). How I perceive and manage my illness. *Schizophrenia Bulletin, 15*(2), 197-200. https://doi.org/10.1093/schbul/15.2.197

[173] Deegan, P. (1987). *Recovery, rehabilitation and the conspiracy of hope* (p. 2). Paper presented at There's a Person in Here: The Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane.

[174] Deegan, P. (1987). *Recovery, rehabilitation and the conspiracy of hope* (p. 13). Paper presented at There's a Person in Here: The Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane.

[175] A preferred term within the movement, madness was preferable to psychiatric language.

> views from a high sturdy platform built by historical privilege, educations, money and authority.[176]

The above text signified the absence of rights, and the lack of agency even within the provision of a 'space'. Highlighting power relations arising from the notion of expertise, early iterations of inclusion for *service users* were noted by O'Hagan as tokenistic. However, through the 1990s, *recovery* as an approach was co-opted into mental health service provision in several Western countries, including Aotearoa New Zealand, as *personal recovery* and *clinical recovery*. *Personal recovery* represented the individual's experience; their journey through illness and identification of the conditions increasing overall life satisfaction, described as a meaningful life with or without symptoms.[177,178] *Clinical recovery*, constructed as an approach for service provision, defined conceptual principles to guide policy and clinical practice with the aim to reduce symptoms and increase functioning and independence.[179] As a productive power drawing from disciplinary tactics, *recovery* emerged as strategy within Aotearoa New Zealand policy to increase the participation of *service users* in their treatment, promoting all persons to take on responsibility for their own health and wellbeing; for example, by adopting healthy lifestyles:

> All New Zealanders will need to: look after their own mental health and wellbeing; support infants, children and young people in their social and emotional development and build their resilience so that they can weather future adversity; support people who are experiencing mental health or addiction issues; and better inform others who would stigmatise or discriminate against those people. In these ways all New Zealanders can create inclusive communities that play their part in supporting recovery.[180]

Resonating with discourse discussed in Chapter Five, that everyone was potentially sick, and neoliberal notions of responsibility discussed in Chapter Six, *recovery* was constructed as a journey and as an end goal specifically for people experiencing mental

---

[176] O'Hagan, M. (2014). *Madness made me: A memoir* (p. 154). Open box.

[177] Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11. http://dx.doi.org/10.1037/h0095655

[178] Deegan, P. (1987). *Recovery, rehabilitation and the conspiracy of hope.* Paper presented at There's a Person in Here: The Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane.

[179] Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be.* Author.

[180] Ministry of Health. (2012). *Rising the challenge: The mental health and addiction service development plan 2012-2017* (p. 7). Author.

illness, but a possibility for all to be involved. Integrated into service provision, it provided the possibilities for everyone to take responsibility for improving mental health, normalising relations between responsibility and resilience through integration into policy and government guidelines. *Recovery* discourse, therefore, materialised as an instrument and technique for (self)-governance for persons experiencing mental illness and their family in mental health service provision (Foucault, 1978).

A Shift From Care Giver to Facilitator of Recovery

Family, generally absent from the initial texts of *recovery*, emerged in international research from the beginning of the 21st century (cf. Noiseux et al., 2010; Waller et al., 2019; Wyder & Bland, 2014). Constructed as facilitating and hindering *recovery* through the nature of intimate relationships, roles, and interactions (Reupert et al., 2015), possibilities became visible for examining and shaping family conduct conducive to the function of *recovery*. The integration of family into a framework of *recovery*, as opposed to purely supporting the individual's *recovery journey*, also emerged, as in this text taken from an Australian journal for social workers:

> The role of the mental health workers becomes that of assisting families to move beyond the limiting caring roles, of encouraging families to let go of some of their carer role, and allowing some risk-taking for their family member. Paradoxically, by letting go of control, they gain more control over their own lives. This is potentially one of the most challenging parts of the family's recovery journey and is intimately related to the task of self-determination and control.[181] [emphasis added]

Integration of the family into the framework of *recovery* provided another iteration of family maintaining their relative's sickness. In the above example, family limited the individual's *recovery journey* through an inability to relinquish constraints placed on a person through the *carer* position and *risk-averse* attitudes. This text provides an example of the responsibilisation of family for the success of *recovery*, through their own *recovery journey*, also noted in guidelines and policy in Aotearoa New Zealand.

'Rising to the challenge 2012-2017: The mental health and addiction service development plan' reproduced neoliberal discourse through the assertion that everyone

---

[181] Wyder, M., & Bland, R. (2014). The recovery framework as a way of understanding families' responses to mental illness: Balancing different needs and recovery journeys. *Australian Social Work, 67*(2), p. 191. https://doi.org/10.1080/0312407X.2013.875580

was accountable for fostering resilience in the face of adversity to manage their own mental health wellness, with family taking a pivotal position:

> Families and whānau have a fundamental role in supporting recovery and wellness and their participation in service planning and delivery will be critical to the successful implementation of this Plan.[182]

Recovery supported a shift of emphasis on family from the position of *caregiving* (dominant discourse as noted in the previous chapter) to a position of facilitating *recovery*, a further alteration of responsibility regarding the achievement of service outcomes. *Recovery* emerged, co-opted into service provision, as a disciplinary tactic to develop the skills of the whole family unit to support the person under services to manage the illness/condition and manage their own health and *wellbeing*. *Recovery's* inclusion of family constituted a shift from the personal to the social, enabling the family to take on the facilitation of *recovery* (individually and collectively) through an intersection of health literacy and self-examination. Mechanisms of self-examination and engagement in *recovery*-orientated practices provided possibilities for family to identify the potential sources inhibiting *recovery,* such as through positions of caring or the stressors arising from intimate relations. *Recovery* thus became an unsigned (and potentially signed) contract between those under services, and their family to "bind them into professional powers and expert norms in new ways" (Rose, 1999, p. 165); a strategy of investment organised through self-management techniques meeting service outcomes.

Recovery also provided possibilities of power for family in relations with *consultation* and privacy. Possibilities for *consultation* with family without the consent of the person experiencing compulsory assessment surfaced through the notion of *recovery* within the 'Guidelines to MHA, 1992':

> Consultation may require the mental health practitioner or responsible clinician to disclose personal and health information about a patient or proposed patient to their family or whānau. They need to do so particularly when developing a treatment, discharge or recovery plan in which family or whānau will be involved in maintaining a person's wellness in the community. The disclosure of

---

[182] Ministry of Health. (2012). *Rising to the challenge 2012-2017: The mental health and addiction service development plan* (p. 7). Author.

> information for the purposes of consultation under section 7A is not a breach of the Privacy Act 2020 or Health Information Privacy Code 2020.[183]

Situated within the practices of treatment and discharge planning, *recovery* stipulated inclusion of family be prioritised over privacy in the 'Guidelines to the MHA, 1992' when supporting wellness. In Chapter Six, *risks*, in the forms of harm to self or others, was a key condition enabling family involvement to override the wishes of the patient.[184] *Recovery* in the community could now be considered by the *responsible clinician* as justification to consult and potentially include the family within decision-making. However, with the authority to do so remaining with the responsible clinician, possibilities for excluding family continued through notions such as 'not in the best interests of the patient' even within the strategy of *recovery* as a mechanism for living well in the community.

The Emergence of Recovery and Wellbeing as Dominant Discourses in Legal Processes

The notion of community wellness also materialised in policy to further integrate the notion of *recovery* within the individual, within family and whānau, and within the general community, but in a very different sense. Pulling together the individual and social aspects of health, the notion of *recovery* was broadly used in 'Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan' as a response to COVID-19:

> this plan recognises that psychosocial recovery requires both mental and social wellbeing. In fact, mental and social wellbeing are largely dependent on each other, and are difficult concepts to separate.[185]

Represented as a *recovery framework* for whānau and communities, *recovery* as a notion had shifted in meaning in 'Kia Kaha, Kia Māia' to integrate the broader concept of *wellbeing* without an explicit underlying mental illness or disorder. *Wellbeing* was constructed as feeling:

---

[183] Ministry of Health. (2022a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (p. 39). Author.

[184] The MHA, 1987, as an example.

[185] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan* (p. 2). Author.

> safe and secure and feel a sense of belonging, identity, connected, valued, worthy, accepted for who we are, and hopeful for the future.[186]

This *wellbeing* construct linked in family and whānau, and communities as sociocultural environments to enable *wellbeing*; hence the responsibilisation of the population in responding to COVID-19. With the pandemic experienced by everyone, *recovery* as a notion was also for everyone, blurring boundaries between those diagnosed with mental illness and the collective "stress, worry, fear and grief in the face of significant change and disruption".[187] This strategy of blurring differences between those diagnosed with a *mental illness* and persons experiencing distress echoed strategies to normalise *community care* and deinstitutionalisation practices in the 1960s (see Chapter Five). The construction of an interdependency between mental and social *wellbeing* reinforced and normalised the community and family as integral to individual wellness and *recovery*. An absence of wellness was constructed as an overarching social event, in this case, a pandemic that, in Aotearoa New Zealand, had a significant impact on the functioning of society as well as individual health.

> This plan has been developed based on six guiding principles: People and whānau centred, community-led, uphold Te Tiriti o Waitangi, achieve equity, protect human rights and work together.[188]

An alternative iteration of *recovery* emerged in 'Kia Kaha, Kia Māia'—a psychosocial construct in relations with rights, te Tiriti o Waitangi, *equity*, and community-led solutions. Responsibility for *recovery* and achievement of *wellbeing*, rested with individuals and community through notions such as "equipping individuals", "empowering community", and "collectively building" the fundamentals for *wellbeing*. All of these strategies supported greater involvement of family and whānau, as community investment in productive individuals situated *recovery* as a collective goal. The principle of community-led practices was noted to:

---

[186] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan* (p. 31). Author.

[187] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan* (p. 1). Author.

[188] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing Recovery plan* (p. v). Author.

> Promote strengths-based recovery, focused on prevention by enhancing protective factors and reducing risk factors.[189]

Strengths-based practice, developed from a social work perspective towards the end of the 1990s, provided a focus on a person's, family's, or community's strengths to develop resilience to adversity, as opposed to a focus on deficits (Brun & Rapp, 2001; Bryan & Henry, 2008). Drawing from concepts and strategies of preventing harm and thus reducing *risks*, strengths-based as a philosophy aligns with *recovery* through challenging deficit, *risk*-based practices.

The latest national inquiry, however, has contended that negative constructions of *risk* witnessed through *risk-averse* practices continue to dominate service provision, including compulsory assessment and treatment practices. *Recovery* and *wellbeing* as strategies to reduce coercive practices (now considered harmful) were represented in the report to promote human rights and thus question the dominance of *risks*:

> Repeal and replace the Mental Health (Compulsory Assessment and Treatment) Act 1992 so that it reflects a human rights–based approach, promotes supported decision-making, aligns with the recovery and wellbeing model of mental health, and provides measures to minimise compulsory or coercive treatment. Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whanau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk.[190]

The above text, representing *recovery* and *wellbeing* within a human rights approach, situated the problem of *risks* as limiting and constraining rights including within decision-making. The shift away from *risks*, through an expansion of *recovery* into the family and the community,[191] provides new alternatives for the foci of *consultation*. Greater emphasis on *recovery* and *positive risk* are noted in the text to increase agency and responsibility of family, whānau and community within decision-making in

---

[189] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan* (p. 5). Author.

[190] Paterson, R., Durie, M., Disley B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He Ara Oranga. Report of the government inquiry into mental health and addiction* (p. 20). Ministry of Health. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

[191] Community incorporating hapū, iwi, community organisations, as examples

consultation practices. The position of family and whānau as *facilitators of recovery* has opened up possibilities for longer-term planning and broader discussions within *consultation*, incorporating a focus on the resources and needs of family and whānau. *Burden of care* discourse within *consultation* (including emotional, physical and financial aspects) and the strengths attributed to family and whānau (including broader extensions, such as iwi, hapū, and community) has made multiple social structures visible that may be available for involvement in support and avoidance of hospitalisation, a notion echoed in the following mini-chapters on practices arising from discourses of *equity* and *wellbeing*.

Summary

This mini-chapter introduced the concept and strategy of *recovery* as a process and a service approach, including new iterations contextual to COVID-19. *Recovery* emerged within liberal rights discourse from those using services in the 1970s and 1980s to critique the power of psychiatry witnessed through compulsory hospitalisation. Co-opted into government policy and mental health service provision from the turn of the 21st century, *recovery* reproduced neoliberal discourse through emphasising personal responsibility to maintain wellness through principles pertaining to the concept of *recovery*. For family, *recovery* functioned as a disciplinary tactic to shift their position, such as from *caregivers* to *facilitators of recovery*, providing possibilities for *partnership* within the dictates of psychiatry. It also promoted neoliberal values as a self-investment strategy (Rose, 1999) for the family to manage its own *wellbeing* through the *facilitation of recovery*.

The COVID-19 pandemic witnessed the use of *recovery* in a different iteration that integrated *recovery* into the community and society, a shift away from its historical connotations with significant mental illness. Coalescing *recovery* and *wellbeing* in policy and guidelines exposed the notion of *recovery* outside the domain of mental health service provision. Within service provision *recovery*, in relations with *wellbeing,* emerged in the national inquiry 'He Ara Oranga' to challenge the dominance of *risks* in mental health service provision and legal processes providing the possibilities for different applications of *consultation* focused on *recovery principles*.

Resistance to the focus on negative constructions of *risk*, as articulated in 'He Ara Oranga', commonly situated *recovery* in relation to *equity* and *wellbeing* through a sense of shared responsibility between the clinical team and family. In the next mini-chapter, the notion of *equity* as dominant discourse in social policy and practices is explored. The example of 'Whānau Ora' as a practice, providing opportunities for governance and resistance, is analysed to identify implications for family and whānau in *consultation* practices.

Equitable Constructions of Health

In the last mini-chapter, I argued that iterations of *recovery* as a philosophy and approach emerged to challenge psychiatry, supporting a shift in practices that increased the agency of people using services. Its integration of the family and then the wider community involved establishing relations with notions of community wellness, *wellbeing*, and human rights. These notions problematised the dominance of *risk* discourses, providing possible alternative foci for *consultation*, such as in the 'Guidelines to MHA, 1992'[192] through incorporation of *recovery principles*. This mini-chapter explores the notion of *equity*, appearing as dominant discourse in contemporary policy and in the national inquiry 'He Ara Oranga' as a focus for change. I contend that *equity* is positioned to resist the dominance of *risk* discourses through targeting disparities arising from activity and exclusion (Rose, 1999) through promoting a sense of shared responsibility. 'Whānau Ora' is introduced as a concept and strategy, providing greater service support for family and whānau to take on and be a support system. This mini-chapter concludes with an analysis on the possibility for 'Whānau Ora' as a strategy to resist State governance of Māori, with iterations of *consultation* a possible tactic for service access and tino rangatiratanga in the forms of self-determination and absolute authority.

Problematising the MHA, 1992

For the national election of 2017, the Labour party's first 100-day plan in office included the establishment of a ministerial inquiry into mental health service delivery. Referring to the 'People's Mental Health Report' (Elliott, 2017) as influential data requiring a review of service provision, the government announced an inquiry at the start of 2018, leading to the publication of 'He Ara Oranga' (Paterson et al., 2018) at the end of the year. This inquiry problematised mental health service provision through a variety of mechanisms. *Recovery* and *wellbeing*, human rights, and *equity* were used as notions to critique the MHA, 1992 as outdated and, thereby, an unwelcome link to the

---

[192] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992.* Author.

coercive and sovereign nature of psychiatry. Authority of the report was situated with the 'voices of New Zealand people' constituted by submissions from individuals, organisations, and communities. The MHA, 1992 was problematised as not meeting commitments, such as to Te Tiriti o Waitangi and international guidelines (cf. WHO, 2017). 'He Ara Oranga' depicted the MHA, 1992 as enabling sovereign forms of power, of control and coercion in the forced movement of bodies, echoing critique from the *anti-psychiatry* and *service user* movements. Repealing and replacing the Act was a strategy proposed to address significant human rights breaches:

> We heard that New Zealand needs a human rights and mental health approach to be recognised in law to honour our international treaty obligations. People called for repeal and replacement of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) and an end to seclusion and restraint. Even in 2018, shame and stigma shape attitudes and act as barriers to seeking help. The Mental Health Act embeds archaic and risk-averse attitudes that cause clinicians to opt too readily for coercion and control.[193]

In practices of compulsory assessment treatment, the call in 'He Ara Oranga' for a human rights approach in legal processes, situated the MHA, 1992 as lacking in rights through practices dominated by negative constructions of *risk*. Use of the term 'archaic' in the above text signified relations with the past; with historical practices such as institutionalisation and the large psychiatric hospitals that operated through mechanisms of commitment and control. Discourses of *risk*, noted in the previous decades as underpinning safe *community care* practices (see Chapter Six) had shifted in function, now producing poor outcomes through association with notions of control and coercion.

Shame and stigma of mental illness were noted in the above text as acting as barriers for people seeking help. Research concurring with this statement has taken a population approach to identify specific barriers to different cultural groups. In Aotearoa New Zealand, research into Māori, Pasifika, and Asian populations, as an example, has been used as a tool to identify the notion of *inequity* in health care provision. Asian presentations to mental health services in the Waitemata District Health Board in

---

[193] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction* (p. 10). Ministry of Health. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Auckland indicated multiple factors including stigma as leading to a high proportion of late presentations and people presenting as *acutely unwell.*[194]

Barriers for Māori populations accessing healthcare included poor communication; hostility; racism;[195]operational accessibility, such as a focus on the individual and not whānau; and stigma arising from a lack of choice in the delivery of services.[196] Research into Pasifika peoples' experiences has indicated stigma, mistrust of services from individualistic service delivery, and an absence of spirituality as barriers.[197] Intersections between cultural differences, stigma concerning mental illness, and service access is increasingly reported as leading to *inequity* in health outcomes in policy, emphasising structural changes in processes and practices as leading to *equitable* health.[198]

Equity was offered in the national inquiry 'He Ara Oranga' as a concept and strategy to increase public confidence in mental health service delivery, through impacting health outcomes:

> The purpose of this inquiry is…a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.[199]

With a focus on *equity* to achieve better outcomes for specific populations, the inquiry problematised the MHA, 1992 through acknowledging a lack of fairness within service provision, enabling possibilities to reframe compulsory actions within mental health service provision. The notion of *equity* in contemporary policy for Māori, Pasifika, and

---

[194] Lim, S., Mortensen, A., Feng, K., & Yeo, I. (2015). Late presentations by Asian people to WDHB mental health inpatient services project report. https://ecald.vps2.netpotential.co.nz/Resources/Publications/Health-Related

[195] Espiner, E., Paine, S.-J., Weston, M., & Curtis, E. (2021). Barriers and facilitators for Māori in accessing hospital services in Aotearoa New Zealand. *The New Zealand Medical Journal* (Online), *134*(1546), 47-45.

[196] Haitana, T., Pitama, S., Cormack, D., Rangimarie Clark, M. T., & Lacey, C. (2023). 'It absolutely needs to move out of that structure': Māori with bipolar disorder identify structural barriers and propose solutions to reform the New Zealand mental health system. *Ethnicity and Health, 28*(2), 234-256. https://doi.org/10.1080/13557858.2022.2027884

[197] Fa'alogo-Lilo, C., & Cartwright, C. (2021). Barriers and supports experienced by Pacific peoples in Aotearoa New Zealand's mental health services. *Journal of Cross-Cultural Psychology, 52*(8-9), 752-770. https://doi.org/10.1177/00220221211039

[198] Minister of Health. (2023). *New Zealand health strategy*. Author.

[199] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction* (p. 6). Ministry of Health. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

the general population has been used to signify: differences between groups and recognising different needs; the identification of health disparities and factors leading to *inequities* (such as housing quality and poverty); a tool to evaluate service provision, such as resource provision for different groups; improvement in health outcomes for specific groups; and relations with Te Tiriti o Waitangi, overall representing the notions of fairness and social justice.[200,201]

> Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.[202]

In the above text from the WHO, *equity* represents fairness from inequalities experienced by different populations. In this sense, *equity* could be seen as a concept of justice concerning health. Health is situated as a fundamental human right, established universally within the document 'Universal Declaration of Human Rights' [UDHR] in 1948 as a standard of living enabling health and *wellbeing*. The 30 articles of the UDHR, established in response to human rights abuse during World War II, included notions such as equality, freedom from discrimination, and social security comprising cultural rights. From this perspective, the problematisation of the MHA, 1992 concerning *inequity* signifies unfairness in mental health service provision for specific groups. Equality, freedom from discrimination, and cultural rights are considered in this thesis as notions that materialise in different forms at different times enabling the potential for *equity*. *Equity* is thus positioned in this study as a complex and shifting construct that can be used to signal the presence and absence of human rights within changing practices.

Problematising 'Risky Populations'

The 'New Zealand health strategy' featured *equity* as a goal for improving the future health of the nation:

---

[200] Ministry of Health. (2023). *New Zealand health strategy*. Author.

[201] Ministry of Health. (2023). *Pae tū: Hauora Māori strategy*. Author.

[202] World Health Organization. (2024). *Health equity*. https://www.who.int/health-topics/health-equity#tab=tab_1

> The New Zealand Health Strategy's vision of pae ora is underpinned by two long-term goals. These are: to achieve health equity for our diverse communities, and especially for Māori, Pacific, disabled and other groups who currently have poorer outcomes; to improve health outcomes for all New Zealanders.[203]

The Pae Ora (Healthy Futures) Act, 2023 situated *equity* in health outcomes as an administrative strategy targeting populations within general health care service delivery. Practices associated with the Pae Ora Act included the disestablishment of District Health Boards to a centralised function under the name of Te Whatu Ora (Health New Zealand) and the establishment of Te Aka Whai Ora (the Māori Health Authority). Te Whatu Ora, signifying the 'weaving of wellness' represented the notion of 'weaving' European and Māori knowledge and practices to constrain the dominance of European and Western discourse within health service provision.

The notion of *equity* was developed as a tactic to improve health outcomes for Māori and other groups, such as Pasifika and disabled people.[204,205] For Māori, Te Aka Whai Ora (the Māori Health Authority) functions, as outlined in the Pae Ora Act, 2023, included joint planning and delivery of services responding to the objectives as well as needs of whānau, hapū, and iwi to support *equity*; a construction of *partnership*. *Inequities* in healthcare outcomes had been attributed to differences in social circumstances experienced by specific groups, leading to differences in mortality rates and other measures, such as *wellbeing*.

---

[203] Ministry of Health. (2023). *New Zealand health strategy* (p. 4). Author.

[204] Ministry of Health. (2023). *New Zealand health strategy*. Author.

[205] Te Whatu Ora Health New Zealand. (2023). *Our whakapapa*. Retrieved from https://www.tewhatuora.govt.nz/whats-happening/about-us/who-we-are/our-whakapapa/#:~:text=the%20main%20line.-,The%20meaning%20of%20Te%20Whatu%20Ora,basket%3B%20a%20basket%20of%20life

Equity as a concept to reduce health outcome disparities through targeted strategies has increasingly surfaced within research,[206,207] guidelines,[208] and policy,[209] constructing mātauranga Māori (knowledge systems) and Te Ao Māori (worldview and cultural practices) as essential considerations for achieving *equitable* health outcomes for Māori. Problematising Māori as an '*at-risk population*', (see Chapter Eight for further discussion) has thus made visible the potential for practices within service provision to cause harm for specific groups through a misalignment with the needs of those particular groups. Misalignment of needs can be represented through statistics, policy analysis, and research; and for Māori, alignment or misalignment with the articles within Te Tiriti o Waitangi.

Relations with Te Tiriti o Waitangi has been taken up within policy[210] and guidelines[211] to resist specific practices seen as particularity harmful and experienced disproportionately by Māori. Seclusion and restraint practices, as examples, associated with compulsory assessment and treatment practices have been critiqued as a human rights abuse disproportionately effecting Māori.[212] The incorporation of the Six Core Strategies© by Te Whatu Ora as an example of targeted actions arising from the notions of human rights and *inequity* for specific populations, has attempted movement away from restrictive practices:

> Promote the use of least restrictive practice by forming a mission, philosophy of care, and guiding values to develop and implement a seclusion and restraint reduction or elimination plan. The guidance, direction, participation and on-going review by executive leadership is demonstrated throughout all seclusion and restraint reduction or elimination projects, plans and service delivery. A

---

[206] Haitana, T., Pitama, S., Cormack, D., Clark, M. T. R., & Lacey, C. (2022). "If we can just dream…" Māori talk about healthcare for bipolar disorder in New Zealand: A qualitative study privileging Indigenous voices on organisational transformation for health equity. *The International Journal of Health Planning and Management, 37*(5), 2613-2634. https://doi.org/10.1002/hpm.3486

[207] Lacey, C., Lawrence, M., Paterson, C., & Every-Palmer, S. (2022). Voices forgotten or a future of inclusion and equity: An Aotearoa New Zealand perspective on better publication of Indigenous mental health research. *Australian and New Zealand Journal of Psychiatry, 56*(8), 895-898. https://doi.org/10.1177/00048674221113

[208] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

[209] Ministry of Health. (2023). *Pae tū: Hauora Māori strategy*. Author.

[210] Ministry of Health. (2023). *Pae tū: Hauora Māori strategy*. Author.

[211] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

[212] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

> commitment to Te Tiriti o Waitangi is modelled through a partnership and shared decision-making approach.[213]

In the above text, a reduction in seclusion and restraint practices is made possible through structural organisation change administered through recognition and integration of Te Tiriti o Waitangi principles. Notions, such as *partnership* and tino rangatiratanga (self-determination), provide opportunities for incorporating Te Ao Māori (worldview and cultural practices) into service provision. In a broader sense, the mobilisation of *equity* in relations with human rights has provided the justification for re-structuring micro and macro elements of the health system.

> We are proud to say the vision for Pae Tū: Hauora Māori Strategy (Pae Tū) is pae ora – healthy futures for Māori. Pae ora reflects a holistic, indigenous worldview and includes three interconnected elements: mauri ora, whānau ora and wai ora. Improvements must be made across each of these elements for Māori to live with good health and wellbeing... This strategy will make a real positive impact on the lives of whānau Māori. It will do this by ensuring the new health system upholds Te Tiriti o Waitangi, improves equity and enhances intergenerational wellbeing.[214]

The above statement from the Minister and Associate Minister of Health in the foreword of ‘Pae Tū: Hauora Māori Strategy’ authorised Te Ao Māori (worldview) as vital to achieve better health for whānau Māori. Inclusion of intergenerational *wellbeing* within the text, acknowledged the historical influences on *wellbeing* arising from colonisation, and resulting constraints on Te Ao Māori (cultural practices) (Lacey et al., 2022). It emphasised three aspects of mātauranga Māori (see Chapter Six for definitions) to achieve better health outcomes for Māori. Mauri Ora, Wai Ora, and Whānau Ora were constructed within policy, resisting Western individualist notions of health and *wellbeing* through connections between the self, family, and the environment.

Mauri Ora can signify the essence of life, binding body and spirit, which thrives through connections and ideas. Mauri Ora in connection with cultural heritage and identity has been noted to strengthen *wellbeing* through the integration of cultural beliefs into

---

[213] Te Pou. (2020). *Six core strategies© service review tool: New Zealand adaption* (2nd ed.). Strategy 1: Leadership towards organisational change (p. 4). Author.

[214] Ministry of Health. (2023). *Pae tū: Hauora Māori strategy* (pp. iii-iv). Author.

practices[215]. Within the ‘Whakamaua Māori Health Action Plan’,[216] Mauri Ora was constructed as ‘healthy individuals’ interconnected with Whānau Ora and Wai Ora. Wai in te reo Māori signifies water but can also refer to a person, linking a person with place. Wai Ora can, therefore, refer to the connection between hauora (*wellbeing*) and the environment (Severinsen & Reweti, 2021), and used to signify ‘healthy environments’.[217]

Whānau Ora has been constructed as ‘healthy families’, a term commonly occurring in policy and guidelines since its political inception in ‘He Korowai Oranga: Māori Health Strategy’[218] as a concept to involve family and whānau in supporting individuals to improve overall Māori *wellbeing* (Boulton, 2019; Kidd et al., 2010). The concept of Whānau Ora has also surfaced in research as a strategy to improve *equity* in healthcare practices through deliberate involvement and resourcing of families (Haitana et al., 2022a; O'Connor, 2021). Whānau Ora, as a concept and strategy, is noted in my research as having substantial implications for future iterations of *consultation* and is explored in more detail in the following sections as an administrative tactic increasing notions of *equity* and broader human rights within social policy, through the integration of family and whānau into policy planning and practices.

‘Whānau Ora’ as a Technology for Active Inclusion of Family

The construction of ‘Whānau Ora’ as a practical tactic for improving health outcomes for Māori emerged within ‘He Korowai Oranga: Māori Health Strategy’:

> Inequalities between the health status of Māori and other New Zealanders are well documented. Across New Zealand, health inequalities are greater for those in more deprived socioeconomic groups. Whānau are not only over-represented in the more deprived groups, but also appear to experience further inequalities over and above those experienced in the same socioeconomic groups.[219]

Use of the word whānau in the above text represented Māori in general as overrepresented in statistics and, therefore, as a population group experiencing

---

[215] He Paiaka Tōtara. (2020). *Mauri ora tai pari*. Retrieved from https://hepaiakatotara.org/mauri-ora-tai-pari#:~:text=The%20way%20mauri%20is%20expressed,potential%2C%20ideas%2C%20and%20connections

[216] Ministry of Health. (2020). *Whakamaua Māori health action plan*. Author.

[217] Ministry of Health. (2020). *Whakamaua Māori health action plan*. Author.

[218] Ministry of Health. (2002). *He korowai oranga: Māori health strategy*. Author.

[219] Ministry of Health. (2002). *He korowai oranga: Māori health strategy* (p. 19). Author.

‘exclusion’ (Rose, 1999) within health service practices. Measurement normalised Māori in relations with deprivation in policy to enable strategies specifically targeting whānau (Māori and family) through resource provision (Foucault, 1978). Policy, ‘He Korowai Oranga’ supported resistance to the individualistic nature of healthcare service provision through a greater focus on family and whānau involvement to achieve gains for Māori. Administrative strategies, including the development of the Māori workforce and partnerships between the District Health Boards and iwi, were presented to tackle the notion of inequality; used in the above text to signify differences between Māori and non-Māori. *Inequity* as a term, signifying differences as unjust and preventable in association with bias, did not appear in the original version of ‘He Korowai Oranga’. In ‘The Guide to He Korowai Oranga’ reproduced 12-years later, the notion of *equity* appeared contextual to the prevention of inequalities through an international lens of social justice:

> The World Health Organization defines equity as the absence of avoidable or remediable differences among groups of people. The concept acknowledges that not only are differences in health status unfair and unjust, but they are also the result of differential access to the resources necessary for people to lead healthy lives.[220]

Relations between the notion of inequality and bias leading to unfair and unjust differences in health outcomes was intersected with resource provision, generating the definition of *inequity* with notions of inclusion and exclusion of populations (Rose, 1999). Using comparable statistics, the ‘Guide to He Korowai Oranga’ constructed active and inclusive populations as achieving better health outcomes through service approaches and access to resources.

The formalisation of ‘Whānau Ora’, as an initiative between the National party and the Māori party in 2010, aimed to build the capacity of Māori service providers, integrate some social and health agencies, and directly fund whānau to provide opportunities and resources to tackle health disparities. The development of ‘Whānau Ora’ as policy initiative and practice provided possibilities for partnership*s* between government and iwi, enabled the creation of non-governmental organisations to directly oversee initiatives, and authorised the generation of the ‘Whānau Ora’ framework (Boulton,

---

[220] Ministry of Health. (2014). *The guide to He korowai oranga: Māori health strategy 2014* (p. 8). Author. https://www.health.govt.nz/publication/guide-he-korowai-oranga-maori-health-strategy

2019). As a framework, the construction of ‘Whānau Ora’ supported shifts away from individualistic notions of *wellbeing*, endorsing greater involvement of family and whānau:

> Shifting the focus from ‘services for individuals’ to ‘wrapping services around whānau’ takes a more holistic view of family wellbeing. Placing whānau at the centre allows those who are often overwhelmed or disempowered to determine what success is to them – encouraging them to develop their own solutions and build their capacity and resilience to become self-managing.[221]

The above text from the website ‘Whānau Ora’ by the Whānau Ora Commissioning Agency, incorporated a blend of neoliberal thinking through notions such as self-management and resilience (responsibility), with Te Ao Māori (worldview) notions of tino rangatiratanga (self-determinism) and collectivism. Blending Western and Te Ao Māori cultural practices through shifts from individual to whānau within healthcare endorsed family involvement and also provided new opportunities for governance as discussed below.

Co-opting or (Mis)appropriating ‘Whānau Ora’ as a Strategy for Governance

> This statement affirms and strengthens the commitment by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in recognising He Whakaputanga (Declaration of Independence)[222] and Te Tiriti o Waitangi (Treaty of Waitangi) principles of tino rangatiratanga (self-determination), the right of Māori to health equity and meeting the needs of tangata whaiora. The concept of Whānau Ora builds on the knowledge and traditions of Māori, and whānau-centred practice… The Whānau Ora Framework carries an expectation that practitioners be equipped to intervene at a collective level, rather than individual, to provide holistic assessment and care encompassing, physical, psychological, socio-cultural, religious/spiritual, and values of Māori. This

---

[221] Whanau Ora Commissioning Agency. (2023). *Whānau ora: About us*. Retrieved from https://whanauora.nz/about-us

[222] In the 1830s concerns by British colonisers that France or the United States might claim New Zealand, led to the British generating ‘He Whakaputanga’ (Declaration of Independence), a document signed by several Māori chiefs, declaring Māori as rulers of New Zealand (Te Ara. (n.d.). Story: He Whakaputanga – Declaration of Independence. https://teara.govt.nz/en/he-whakaputanga-declaration-of-independence#:~:text=In%201835%20northern%20chiefs%20signed,himself%20king%20of%20New%20Zealand

> assumes that cultural practices are appropriately acknowledged and incorporated into treatment of tangata whaiora.[223]

In 2021, the Royal Australian and New Zealand College of Psychiatrists [RANZCP] made a commitment to ‘Whānau Ora’ and Te Tiriti o Waitangi to improve *equity* in healthcare outcomes for Māori. The above text embedded collectivistic practices as a core tactic to tackle *inequities* in mental health outcomes, witnessed as higher rates for Māori mental illness, suicide, and addictions per population since the 1970s (Lacey et al., 2022). Incorporating Māori values into service provision has provided the potential to shift service provision from the individual towards being inclusive of family and whānau in psychiatric practices. Reminiscent of the incorporation of family into mental health service provision (discussed in Chapter Five), emphasis on family and whānau has provided possibilities for further disciplinary tactics to shape the conduct of family and whānau into meeting the needs of psychiatry and service provision (Foucault, 1977). *Equity*, in relations with Te Tiriti o Waitangi, has shaped Te Ao Māori (worldview) as a value previously constrained within *community care* practices. With limited presence of Te Ao Māori (worldview and cultural practices) in mental health service provision constructed as causing *inequity* in health, the inclusion of Māori culture as a solution has conferred a political status on “the ‘indigenous’ authorities of community” (Rose, 1999, p. 189). Rose (1999) contended that population governance can occur through linking into the spaces of specific communities, constructing ‘new’ expert knowledge within institutions. Categorisation of Māori identity within psychiatry compels a form of ‘truth’ on Māori to act in certain ways befitting to cultural values assimilated into a Western gaze (Foucault, 1994h).

In the previous mini-chapter on ‘*recovery*’, I argued that the incorporation of personal *recovery* into psychiatric discourse produced neoliberal tactics through encouraging self-management and self-responsibility for individuals and, later, family members as *facilitators of recovery*, drawing from the notions of individual and family expertise. *Recovery* as used in ‘Kia Kaha, Kia Māia’[224] also responsibilised communities to overcome the impacts of COVID-19 through community-led strategies of self-management, drawing from the notion of community expertise. As a framework,

---

[223] The Royal Australian and New Zealand College of Psychiatrists. (2021). *Whānau ora*. Retrieved from https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/whanau-ora

[224] Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan*. Author.

recovery has thus had the potential to categorise and objectify those using services, their family and whānau, and communities through notions of expertise. In the above examples, expertise is regulated; shaped through the rules and processes of institutions and governing bodies, through research, and through the constitution of the self (Rose, 1993).

In the above text from RANZCP, acknowledgement of Māori expertise through affirmation of Māori cultural practices and needs has provided 'new' rules through the mobilisation of 'Whanau ora'. This is not new, as witnessed previously through the concept of *biculturalism* and through resistance from Māori (see Chapter Six); however, it encourages shifts from the individual to a collective gaze within contemporary psychiatric practices. It signifies acknowledgement of the need to be inclusive of Māori ways of thinking and doing to tackle *inequity* through the operation of Māori discourses. It also provides the potential for governance, regulating and constraining Māori expertise through the assimilation of Māori values into Western psychiatric practices. This concern was identified in a submission to 'He Ara Oranga' by a non-specified Māori non-governmental organisation collating views from Māori organisations, kaimahi (workers), tangata whaiora (persons receiving services) and whānau:

> Colonisation permits the (mis)appropriation and transfer of power and resources from indigenous peoples to newcomers. This process of transfer is enabled by layer upon layer of new systems established to determine how resources will be obtained and how they are to be redistributed and to whom. These systems, therefore, construct who will benefit and be privileged. These systems are built on new values and new ideas of normal. Through this colonising process Maori move from being normal to being 'different' from Pakeha, non-Maori, non-indigenous norms. Maori rights as tangata whenua are appropriated and are marginalised and reclassified by 'outsiders'.[225]

The above text makes visible colonisation within psychiatric practices through co-opting Māori values in ways that benefit Western service provision. Māori expertise is regulated within the boundaries of Western norms enabling 'othering', highlighting tensions between merging Western and Māori discourses within primarily Western institutions (for further discussion, see Chapter Eight). Retention of Māori culture in

---

[225] Ministry of Health. (2018). *Submissions summary report: Government inquiry into mental health and addiction* (p. 38). https://mentalhealth.inquiry.govt.nz/whats-new/resources/submissions-summary-report/

practices, as argued by Maree Kopua et al. (2020), requires a “scaling down” of Western psychiatry and a “scaling up” (p. 381) of indigenous approaches. Deconstructing oppressive, colonial practices, as suggested in the below text, necessitates the generation of systems enabling tino rangatiratanga (self-determination as absolute authority) on the distribution of resources:

> Let’s commission from a Kaupapa Maori methodology. “We need to create a system where whanau can come in and out as they see fit.” We want them to be able to walk in the door under the principles of Whanau Ora and access whatever they need: point of access care to entire family (kaimahi Maori).[226]

The above text, taken from another submitter to ‘He Ara Oranga’ noted resistance through tino rangatiratanga (self-determination as absolute authority) for whānau within a system enabling full access to care. The concept and strategy of ‘Whānau Ora’ and, more broadly, the notion of *equity*, provides the possibility of different iterations for *consultation*, shifting power from the responsible clinician to whānau. From within the principles of ‘Whānau Ora’, greater agency of whānau in decision-making practices may be possible in moving away from the individual in relations with negative constructions of *risk* to the needs of whānau in relations with resources and service access. The emergence of ‘Whānau Ora’ as strategy has provided possibilities for Māori resistance to Western practices in mental health service provision through promotion of greater agency of the family and whānau within decision-making. ‘Whānau Ora’ may, therefore, provide possibilities to shift practices away from Western paradigms of assessment and treatment, with *consultation*, or iterations of, as a tactic to do so.

Consulting Māori in the latest ‘Guidelines to the MHA, 1992’ noted the limitations of psychiatry’s gaze on the individual as *patient*, and shifts towards greater inclusion of family:

> Māori hauora and wellbeing encapsulate an ‘interwoven relationship’ between whānau, hapū and iwi. The Act’s general emphasis on the individual patient or proposed patient is in conflict with ‘whanaungatanga’, a concept of interdependence and interconnectedness between all members of the whānau, including the tangata whai ora. However, section 5(2)(a) and (b) of the Act emphasises the importance of these connections by requiring services to be

---

[226] Ministry of Health. (2018). *Submissions summary report: Government inquiry into mental health and addiction* (p. 39). https://mentalhealth.inquiry.govt.nz/whats-new/resources/submissions-summary-report/

> delivered with proper recognition of these relationships, and the importance of these relationships to an individual's wellbeing.[227]

The shift in *consultation*, as noted in the above text, from individual family member(s) (as in the *principal care giver*) to whānau, has opened up possibilities for further governance strategies on Māori within Western discourse through co-opting cultural values and practices. However, attempts to assimilate Māori cultural practices within Western systems, including law, has the potential for further resistance regarding the operation of systems. Integration of Māori concepts, such as 'whanaungatanga', as noted in the above text, highlights possibilities for conflict in the emergence of Western and Māori worldviews. In concurrence with *recovery*, as discussed in the previous mini-chapter, and *wellbeing*, as discussed in the next, *equity* as a discursive construct has emerged as a tactic and condition of power relations between Western and Māori discourses supporting broader shifts from individualism to collectivistic practices shaping mental health service provision, and thus could shape future iterations of *consultation* from within an *equity* gaze.

Summary

In this mini-chapter I have argued that constructions of *risk,* including the notion of '*risky populations*' were through an *equity* lens, enabling the problematisation of the MHA, 1992. *Equity*, in highlighting disparities between different population groups, problematised service access and the oversight of resource distribution as a cause of health and wellbeing disparity. Equity discourses made mātauranga Māori visible as a technology for achieving *equity*. This notion surfaced through research, policy, guidelines, and the Pae Ora (Healthy Futures) Act, 2023, authorising Te Ao Māori (worldview and cultural practices) as a pathway for *equitable* outcomes.

I have argued that 'Whānau Ora' as a function of *equity* has acted as an administrative strategy of biopower to support service access and resources, such as through the integration of some health and social agencies providing services for, and directly funding, Māori whānau. Its integration into State institutions and agencies, such as the RANZCP has, however, provided possibilities for governance through 'othering' and regulating Te Ao Māori (worldview and cultural practices) within systems dominated by Western discourses, making colonisation visible within psychiatric practices. The

---

[227] Ministry of Health. (2022a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (p. 45). Author.

construction of tino rangatiratanga as absolute authority was one tactic of Māori resistance, enabling better access for whānau and challenging the misappropriation of Te Ao Māori (worldview) through its co-option by the State and Western agencies.

I have also argued that *equity*, as a function of service access and resources, provides possibilities for different future iterations of *consultation*. ‘Whānau Ora’ as strategy has provided a greater focus on the family and whānau within decision-making, problematising individualism and promoting a collectivistic gaze within compulsory assessment and treatment. Emphasis on the individual within the MHA, 1992 was problematised within the latest guidelines to the Act as conflictual to whanaungatanga (interconnectedness between family and whānau members), impacting individual *wellbeing*. “Wrapping services around whānau”[228] could signal further possibilities for improving health outcomes for Māori through greater integration of whānau, hapū, and iwi within practices.

In the final mini-chapter, the notion of *wellbeing* is added to the exploration of *recovery* and *equity* as resistance to a focus on negative constructions of *risk* in mental health service provision. *Wellbeing* is introduced as a construct of progress and transformation; a broader understanding of health that can be linked to Māori frameworks of health and *wellbeing*. *Wellbeing* is analysed as an investment; constructing family and whānau as central to health through the incorporation of Te Ao Māori (worldview) into contemporary policy and practices and providing implications for future iterations of *consultation*.

Constructing Progress: From ‘Ill’-being to ‘Well’-being

In the previous mini-chapter on *equity*, I argued that ‘Whānau Ora’ emerged at the start of the 21st century to reduce health disparities in outcomes between Māori and non-Māori in health service provision. A collectivistic approach, recognising the notion of whanaungatanga and relational care structures emerged to construct family and whānau as an active population to achieve health gains. Although ‘Whānau Ora’ provided possibilities for tino rangatiratanga (self-determination) for Māori through greater access to resources, its integration into Western constructs, such as psychiatry, also provided opportunities for governance shaping the conduct of family and whānau to meet the needs of psychiatric practices. This final mini-chapter analyses the notion of

---

[228] Whanau Ora Commissioning Agency. (2023). *Whānau ora: About us*. Retrieved from https://whanauora.nz/about-us

wellbeing, often portrayed in relations with *equity* and *recovery*, and its possibilities as a notion to shape new iterations of *consultation* for family and whānau in compulsory assessment and treatment.

The Visibility of Well-being as a Construct of Progress

A report by the Mental Health Commissioner[229] within the function of monitoring and advocacy of mental health services situated the growing materiality of *wellbeing* to signify progress. Quoting 'He Ara Oranga' (Paterson et al., 2018), *wellbeing* represented transformational change, enabling *equitable* outcomes and hope for a new system providing healthcare:

> The hope set by He Ara Oranga, the report of the Independent Inquiry into Mental Health and Addiction, is nothing short of transformative. The challenge laid was for a new system with "mental health and wellbeing for all at its heart: where a good level of mental wellbeing is attainable for everyone, outcomes are equitable across the whole of society, and people who experience mental illness and distress have the resilience, tools and support they need to regain their wellbeing".[230]

In the above text, and further explicated by the Mental Health Commissioner, the concept of *wellbeing* represented a 'new start' for all New Zealanders. Echoing text from 'Rising to the Challenge'[231] that everyone is responsible for their own health and *wellbeing*, responsibility and resiliency functioned to improve the health of persons experiencing mental illness and reduce distress for the general population. Notions of building and strengthening resiliency appeared in 'Rising to the Challenge' as developing skills to avoid and cope with future adversity. The concept of resiliency also encompassed the notion of 'protective mechanisms' (Rutter, 1987) providing the space for family and whānau as support systems and reducing vulnerability and *risks* of developing illness. With mental illness commonly associated with stress (see Chapter

---

[229] Health and Disability Commissioner. (2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Author. https://www.hdc.org.nz/our-work/mental-health-addictions/monitoring-and-advocacy-report-of-the-mental-health-commissioner-2020/

[230] Health and Disability Commissioner. (2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner* (p. 5). Author. https://www.hdc.org.nz/our-work/mental-health-addictions/monitoring-and-advocacy-report-of-the-mental-health-commissioner-2020/

[231] Ministry of Health. (2012). Rising to the challenge: The mental health and addiction service development plan 2012–2017. http://www.health.govt.nz/system/files/documents/publications/rising-to-the-challenge-mental-health-addiction-service-development-plan-v2.pdf

Five), personal resiliency to illness provided the justification for structural changes in systems through strength-based approaches, including personal responsibility.

> Ultimately, we believe that wellbeing must be addressed as a cross-sector, whole of life, whole system, whole community issue and opportunity. This requires a response that transforms the system from thinking, practices and frameworks that were designed in the last century to responses that are relevant and responsive to the needs of people and communities in this century (NGO).[232]

The concept of *wellbeing* was noted as an opportunity for transforming services to better respond to the problems experienced in contemporary times, indicating a different set of problems from the past, and requiring integrated, holistic service provision. The policy ‘Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing’, situated *wellbeing* with notions such as safety, connection, and belonging:

> ‘Mental wellbeing’ is one component of broader wellbeing. Positive mental wellbeing is most likely when people feel safe, connected, valued, worthy and accepted and have a sense of belonging, identity and hope for the future. Mental wellbeing means being able to adapt and cope with life and life’s challenges and feeling that your life has meaning, as well as experiencing feelings of contentment or general happiness.[233]

Although the above text confirms the importance of resilience to achieve *wellbeing*, individual health and happiness had increasingly drawn from positive social psychology; from notions of identity, of hope for the future, acceptance and belonging within society. A greater focus on individual *wellbeing*, as arising through community relations and integration, akin to concepts within *recovery*, has surfaced within the last 5-years as discourse, made visible in the national inquiry (Paterson et al., 2018), in policy (Minister of Health, 2023a, 2023b; Ministry of Health, 2021), and in law (Mental Health and Wellbeing Commission Act 2020).

In drawing from concepts of positive social psychology, *wellbeing*, used to signify relations between illness and individuals, family, community and population, subtly resists psychiatric discourse and its need to understand the body through focusing on the

---

[232] Ministry of Health. (2018). *Submissions summary report: Government inquiry into mental health and addiction* (p. 32). https://mentalhealth.inquiry.govt.nz/whats-new/resources/submissions-summary-report/

[233] Ministry of Health. (2021). *Kia manawanui Aotearoa: Long-term pathway to mental wellbeing* (p. 10). Author.

problematic and categorising through diagnosis. The normalisation of *wellbeing*, circulating in policy, guidelines, and reviews, refuting service provision based on *risks*, coercion, and control, has enabled its materialisation as 'transformational', and as a 'new' approach. However, I contend that *wellbeing* is not really 'new'. My analysis suggests that the traction gained by the Te Whare Tapa Whā model developed by Mason Durie in the 1980s has laid the foundations for the current focus and use of *wellbeing*, as discussed below.

The Construction of Family and Whānau as Wellbeing

'Building on Strengths: A New Approach to Promoting Mental Health in New Zealand Aotearoa' provided several models to promote health including Te Whare Tapa Whā, a model broadening Western constructs of health:

> For Māori, the concepts of health and wellbeing go beyond physical wellbeing. Good health is recognised as being dependent on a balance of factors. Mason Durie's Whare Tapa Whā model of health (1994), describes four components, which represent the four walls of a house and the idea that if one of the of these walls fails, the house will fall. Reflecting a Māori perspective of health, whare tapa whā includes consideration of: te taha Wairua – spiritual health, including the practice of tikanga Māori in general; te taha tinana – the physical aspects of health; te taha hinengaro - the emotional and psychological wellbeing of the whānau and of each individual within it; te taha whānau – the social environment in which individuals live – the whānau of the family, the communities in which whānau live and act.[234]

Te Whare Tapa Whā functioned to resist the monocultural provision of health care service provision in the 1980s, through providing alternative iterations to the notions of health and *wellbeing* from a Māori cultural perspective. As discussed in Chapter Six, resistance to dominant Western thinking and practices in healthcare emerged[235] through critiquing racism and subjugation of indigenous beliefs and practices. Taha Māori (Māori perspective), and the notion of *biculturalism* emerged to make visible monocultural thinking and practices, providing possibilities for alternative systems and *partnership*. The 1980s/1990s witnessed growing Western recognition of Kaupapa

---

[234] Ministry of Health. (2002). *Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa* (pp. 43-44). Author.

[235] Ministerial Advisory Committee. (1988). *Puao te ata tu: The report of the Ministerial advisory committee on a Maori perspective for the Department of Social Welfare*. Department of Social Welfare.

Māori (values and principles) and mātauranga Māori (knowledge systems) through acceptance of Māori frameworks, such as Te Whare Tapa Whā , and elaborations such as the Meihana Model (Pitama et al., 2007). Nevertheless, resistance remained constrained through resource limitations, co-option of Māori notions into Western systems, and tokenistic practices consisting of cultural checklists, as critiqued in Māori research (McLachlan et al., 2017).

Te Whare Tapa Whā as a framework did, however, broaden the definition of health, and provided an alternative gaze to Western thinking on the family and whānau as *social wellbeing* balancing the health of the individual (within whānau relationships) alongside the components of taha hinengaro (mental and emotional), taha tinana (physical), and taha wairua (spiritual). Whānau, as one wall of the whare (house), has been represented as stabilising and strengthening other dimensions. Moreover, the influence of this model has promoted Te Ao Māori (worldview) of the importance of family and whānau within traditionally Western health frameworks and models.

Whānau, in the framework, did not solely represent the immediate family members; rather, encompassed knowledge within and between the family, whānau, iwi, and hapū (McLachlan et al., 2017). In a broader sense of health, whānau was intrinsically linked to cultural identity in relations with whakapapa (ancestry), language, culture, networks and connection to whenua (land); a pathway to cultural identity and access to Te Ao Māori (the Māori world) (Durie, 2004). Whānau, as a function to communicate and transfer cultural knowledge, values, and skills (Durie, 2006), was noted in research by Moeke-Pickering (1996) as having been constrained by colonisation through changes to how Māori lived. The migration of Māori from larger communities centred around a marae (meeting house) to living in smaller family units within urban areas disrupted ties between family, whānau, iwi, and hapū.

The association between family units disconnected from larger structures of support and poor health and *wellbeing* has been used to critique service provision and health outcomes and disparities, as in the below text taken from Kia Manawanui Aotearoa Long-term pathway to mental wellbeing 2021:

> Kia Manawanui is centred around the vision of pae ora (healthy futures), drawing on Whakamaua: Maori Health Action Plan 2020–2025. 'Pae ora' covers mental wellbeing broadly, taking into account the way people live, grow and develop as individuals and as members of families, whanau, communities and

> their wider environments. The concept of pae ora acknowledges the interrelated aspects of mental wellbeing and encourages us to think beyond narrow definitions of health and services. It also acknowledges the fundamental roles of individuals, whanau, iwi, hapu and communities, and provides a way to think about collective action.[236]

Associations between 'the way people live' and *wellbeing* in the above text was used to critique the limitations of health service provision with a focus on the individual, and thus transform services to better meet the needs of Māori. Positioning family, whānau, iwi, and hapū as possible locations for the attainment of *wellbeing*, permitted a gaze on lifestyles, the interconnectedness of individuals to their family and whānau and community, and, therefore, population grouping and structures. Family and whānau within the context of community have emerged as a potential solution for *wellbeing* and, by association, a solution to reducing and managing mental illness. Drawing from the notion of familial expertise, the text below from the chief executive of Te Aka Whai Ora (Māori Health Authority) situates whānau, iwi and hapu into positions of advisors and recipients of services enabling *wellbeing*:

> The purpose of any health needs analysis is to gather the information required to bring about change that will benefit the wellbeing of our people. This requires accurate data, insightful analysis, appropriate investment and an honest approach to implementation. To meet the needs of our whānau we must offer innovative solutions that are best described by our whānau, hapū and iwi ensuring they reflect the aspirations of our communities, both now and in the future.[237]

The above text represents an investment in whānau which sanctions their experiential agency as a form of expertise. As an object for data collection, health analysis of whānau can be used to define units and households for statistical purposes (Mckenzie & Carter, 2010), providing possibilities for the measurement and examination of whānau to inform policy and service provision (Foucault, 1977). Integration of family and whānau in service provision is not new within the context of service delivery: inclusion of family and whānau in the planning of services was promoted in the previous century in guidelines and policy (cf. Mental Health Commission, 1998; Ministry of Health,

---

[236] Ministry of Health. (2021). *Kia manawanui Aotearoa: Long-term pathway to mental wellbeing* (p. 22). Author.

[237] Te Whatu Ora Health New Zealand. (2024). *Aotearoa New Zealand: Health status report 2023* (p. 3). Author. https://www.tewhatuora.govt.nz/publications/health-status-report/

2000, 2012b). However, integration of Te Ao Māori (worldview) in more recent texts (such as the notion of whānau within a Western view as a construct of *wellbeing*) has acted in a different function; to reconcile differences between Māori and non-Māori.

Within the political health space, common notions of *wellbeing* can be used within diverse communities to signal the inherent values within communities, thus signalling a morality of community conduct. Contemporary health discourse has shifted whānau from geographical, social, and sociological spaces into a moral space, a "space of *emotional relationships* through which *individual identities* are constructed through their bonds to *micro-cultures* of values and meanings" (Rose, 1999, p. 172). Hence, whānau as intrinsically linked to individual health, and co-opted into a Western gaze, positions the family-and-whānau as a construct and a solution of and for *wellbeing*.

In Chapter Six, I argued that the responsibilisation of family and whānau occurred through positions such as *caregiver* and *principal caregiver* within the MHA, 1992. Changing from emphasis on family and whānau, from positions of responsibility to identifying solutions, provides the potential to further shift service provision focus from the individual to family, whānau, and community. Mirroring the shift from institutional to care in the community from the 1950s to the 1970s, the gaze of psychiatry in contemporary relations with the functions of *recovery*, *equity*, *wellbeing*, and notions co-opted from Te Ao Māori (worldview), has again shifted its focus from the individual to the family and whānau and the community. Previously, the shift functioned to identify that which caused and maintained illness, with family represented as a construct of 'illbeing'. The shift to construct family and whānau as a solution for *wellbeing* and by association as a solution to mental illness has provided possibilities for alternate positions and functions within compulsory psychiatric assessment and the notion of *consultation*. In the final section of this mini-chapter, family and whānau as a solution to compulsory assessment and treatment is explored with a focus on strategies and practices akin to *consultation*.

The Construction of Consultation as Cultural Identity

> We heard that recognition of the importance and significance of ties to whanau, hapu, iwi and family group, including the contribution those ties make to wellbeing, and proper respect for cultural and ethnic identity and language rarely form part of psychiatric assessments. They are routinely not addressed by courts, tribunals or others when making decisions about compulsory assessment and

> treatment. We also heard that patients are denied their entitlement to be dealt with in a manner that accords with the spirit of proper respect for cultural identity.[238]

The invisibility of family and whānau association with cultural and ethnic identity was problematised in the above text from the national inquiry ‘He Ara Oranga’ contextual to Section 5 of the MHA, 1992. Section 5 in the Act constructs family and whānau ties as enabling *wellbeing*, with references to ethnicity, language, beliefs, and religion. Drawing from the notion of cultural rights, the inquiry positioned family and whānau as a cultural entity in legal processes. Their subsequent absence in *consultation* proceedings represent reductionism and monoculturalism through a focus on the individual, and a constraint upon *wellbeing* as a collectivistic concept.

The notion of family as a cultural entity integrated into processes of decision making through *consultation* was a contentious issue at the time of its emergence in 1999 as an amendment to the MHA, 1992. *Consultation* emerged as a strategy to enhance the position of family and whānau as a cultural tie; however, resistance to their inclusion was noted at that time (1999) from two legal-based submissions. The ‘Family Law Section of the New Zealand Law Society’[239] noted several concerns arising from practicing *consultation*, including economic, space (as in a venue for family to attend hearings), privacy for the *patient*, and the notion that the interests of the patient might be different to that of the family. The ‘Principal Family Court Judges Chambers’ noted that the amendment:

> will introduce uncertainty, delay and disruption contrary to the intention of the provision. As worded, there is a real danger that this provision would become a minefield of litigation and dissension counter-productive to the interests of the patient.[240]

Amalgamation of *consultation* into Section 5 of the Act did not occur. Section 7A emerged instead, limiting family and whānau to within Eurocentric constructions of individual identity and *wellbeing*. Arguments from the law society and Judges chambers

---

[238] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali’i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction* (p. 40). Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

[239] ‘Family Law Section of the New Zealand Law Society. (1999). Submission 1999 amendment to the MHA, 1992.

[240] Principal Family Court Judges Chambers. (1999, March 1). Submission 1999 amendment to the MHA, 1992.

inferred that inclusion of whānau (as extended family systems) would disrupt the timings of completing specific Sections of the Act. Examples of difficulties included identifying which family members needed to be involved and the time needed to contact them. Differing views from family members was also noted as problematic with possibilities of conflict delaying proceedings.

Family and whānau were thus constructed as a potential problem rather than a potential solution. Separation of *consultation* from Section 5 represented a Western construct of the individual as potentially isolated and disconnected from their family as a right. Redrawing a notion of *consultation* in relations with cultural identity and cultural rights in future iterations of mental health law has the potential to shift the agency of family and whānau in decision-making processes. Broader categories of family and whānau, developed over the years, since the beginning of the 21st century, has provided greater possibilities for extended family system involvement, such as iwi and hapū for Māori, and community from a Western gaze. The dislocation of *consultation* from Section 5 as a tactic of colonisation is discussed in Chapter Eight.

Recovery, *equity*, and *wellbeing* in contemporary policy and guidelines have signalled the intent of moving from the individual to collective responsibility. The integration of mātauranga Māori (knowledge systems) into the thinking of compulsory assessment and treatment practices has enabled critique of the limitations and constraints arising from Western thinking. Māori ways of thinking and doing as a potential solution for addressing problems associated with Māori, has had, and continues to have, implications concerning the general population of Aotearoa New Zealand. Further integration of Māori concepts and strategies into mainstream mental health service provision has the potential to provide alternative iterations of *consultation* that place family and whānau kōrero (discussion) as dominant discourse within legal processes. Integration of Te Ao Māori (worldview and cultural practices) also provides the possibilities for further resistance within contemporary Aotearoa New Zealand society.

Summary

In the final section of this mini-chapter, I have argued that text from ‘He Ara Oranga’, the national inquiry (Paterson et al., 2018), contemporary policy (cf. Minister of Health, 2023a, 2023b), guidelines (Ministry of Health, 2022a), and commentary (Health and Disability Commissioner, 2020) has constructed *wellbeing* as a ‘new’ sign of progress within mental health service provision. However, I identified that notions of *wellbeing* were circulating decades earlier through the model Te Whare Tapa Whā, signifying a Māori cultural understanding of health. I have contended that the construction of family and whānau as *wellbeing*, in drawing from Te Ao Māori (worldview), has enabled the potential for increasing extended family systems within mental health service provision. Greater circulation of *wellbeing* (in relations with Te Whare Tapa Whā) in policy and guidelines has supported the normalisation of broader definitions of health into Western service provision, with family and whānau representing a pou (pillar) of *wellbeing*. This constructs family as *wellbeing* and thereby a potential solution to achieve *wellbeing*. However, disassociation of family as a cultural construct with the MHA, 1992 has constrained this position with the practice of *consultation*.

Chapter Summary

This chapter has identified the occurrence of a contemporary rupture in mental health service provision in the 21st century through a shift towards the notion of collectivism in policy, guidelines, and practices. The emergence of *recovery* as a personal and clinical 'journey' and service approach focusing on the individual, broadened out in policy and practices to include family and community. For family, *recovery* enabled a move from *caregiver* to *facilitator of recovery*, enabling consideration of the family's own *recovery* journey. Replicating previous strategies, such as rehabilitation in outpatient clinics, *recovery* provided the conditions for interventions on family, but this time as *partners* responsible for the *recovery* of the person receiving services and themselves.

The COVID-19 pandemic broadened the use of *recovery* to include community but in ways unconstrained from mental health service provision. *Recovery* became a population goal from the 'distress' caused through significant societal changes, such as through controlling movement ('lockdowns'). This function has had the potential to normalise the concept of *recovery* at a population level, providing the conditions for population governance through notions such as resiliency within neoliberal responsibilisation. Finally, *recovery* was used in the latest national inquiry (Paterson et al., 2018) into mental health and addictions service provision to critique the dominance of *risks* as limiting possibilities for the *recovery* of persons receiving services. *Recovery* has been positioned within the latest guidelines to the MHA, 1992 (Ministry of Health, 2022a) to override privacy, enabling clinicians to share information with family against the wishes of the *patient* during compulsory assessment. I have argued that this function of *recovery* provides the possibilities for different applications of *consultation* in the future, potentially less constrained from the dominance of *risk* discourses.

In the mini-chapter exploring *equity*, I argued that the dominance of *risk* discourses in service provision was used to critique service provision through the lens of *equitable* service provision, problematising health disparities between European and non-European populations. For Māori, an *equitable* lens has provided another way to think about monocultural services provision, through the binary of European individualism and Māori collectivism as values underpinning cultural practices.

'Whānau Ora' emerged as a concept and strategy to provide a greater focus on family and whānau decision-making within mental health service provision, congruent with the shift to include family and whānau within the notion of *recovery*. Moreover, emphasis on *equity* has provided more opportunities for family to access power through a focus on resource access and allocation within service provision. For Māori, this focus has functioned to resist European thinking and doing through increased circulation of Te Ao Māori (worldview and cultural practices) within policy providing the conditions for tino rangatiratanga (self-determination). However, I have argued that the integration of Te Ao Māori (worldview) into policy and service provision risks possibilities for the misappropriation of Māori knowledge, enabling different opportunities for governing Māori within Western-dominated systems, thereby resisting tino rangatiratanga (absolute authority).

Finally, I have contended that the concept of 'Whānau Ora' has possible ramifications for future iterations of *consultation* through emphasis on family and whānau decision-making, inclusive of wider 'family' systems, including iwi, hapū, and community. A more 'collective' approach provides opportunities to shift away from individualistic notions in *consultation*, such as the *principal care giver*, potentially resisting the dominance of *risks* with decision-making through offering other possible responses to compulsory assessment and treatment.

As with *recovery* and *equity*, the function of *wellbeing* in policy has signalled movement from the dominance of European individualism in mental health service provision through integrating Indigenous values of collectivism. I have argued that the concept of *wellbeing* has been part of this 'movement' through its relations with Māori understandings of health, notably, through drawing from concepts from the model Te Whare Tapa Whā. The constitution of whānau as a pou (pillar) of health, provides the conditions to explore 'who' is family and whānau and think about how family and whānau involvement can support the health of everyone within the family unit.

For practices of *consultation*, I have reasoned that the circulation of *wellbeing* as ‘new’ and ‘transformational’ in ‘He Ara Oranga’, the national inquiry (Paterson et al., 2018), has sanctioned broader definitions of health (to include ‘spiritual’ and ‘social’ health with ‘physical’ and ‘mental’), supporting the normalisation of the function of family and whānau as a potential solution for *wellbeing.* Although not ‘new’, this depiction of *wellbeing* as transformational in relations with *consultation* has the potential to reconfigure representations of family-and-whānau, inclusive of the person undergoing compulsory assessment and treatment as a *cultural entity*. This shift in thinking may provide radical opportunities for future iterations of *consultation* through greater incorporation of ethnicity, language, beliefs, and spirituality into decision-making, in conjunction with the other possibilities identified from the notions of *recovery* as *equity* as previously discussed. From a position of a *cultural entity*, family-and-whānau (inclusive of the person undergoing compulsory assessment and treatment) have greater opportunities for freedom from the dominance of psychiatric discourse on differing ‘expressions’ considered mental illness.

The dominance of *risk* discourses in service provision and contemporary critique of this dominance is taken up in the following discussion chapter. The notion of constructing family and whānau as *risks* and the differentiation between what it means to be family and whānau is also explored through the notion of *consultation* as a tool of colonisation.

Chapter Eight: Discussion

Introduction

The aim of this chapter is to explicate and extend my analysis presented in the previous three chapters. The focus of my thesis is to explore how family and whānau *consultation* in compulsory assessment and treatment practices have been constructed through discourses; the subject positions made available for family and whānau; and the implications of these constructions and positions on previous, current, and future iterations of *consultation*. Situating my analysis within a poststructural Foucauldian discourse analysis has enabled me to question the underlying assumptions and functions of texts concerning iterations of *consultation*; that which otherwise appears self-evident through the (re)production, circulation, and normalisation of knowledge (Foucault, 1972; Graham, 2005b). There has been no previous research analysing family and whānau *consultation* in Aotearoa New Zealand from a poststructural stance; hence this thesis has provided a different lens on the topic through the identification of dominant and marginalised discourses shaping practices, adding to research scholarship in the area of family and whānau involvement in practices of compulsory assessment and treatment.

In this discussion chapter, I extend my analysis through exploring two discursive themes I believe to be pertinent to future iterations of *consultation*. The first concerns the construction of family and whānau as '*risky*' regarding their involvement in mental health service provision and practices of *consultation*. The second considers *consultation* as a tool of colonisation from within the notions of individualism and collectivism. These arguments were chosen as they focus specifically on family and whānau *consultation*, and respond to contemporary critiques in 'He Ara Oranga: Report of the government inquiry into mental health and addiction' (Paterson et al., 2018) and directions taken up within recent New Zealand policy (cf. Minister of Health, 2023a, 2023b). Choosing these arguments to focus on and develop does not intend to diminish the significance of other arguments that could be derived from the analysis chapters, as other lines of enquiry are possible. However, the structure of a doctoral thesis naturally limits that which can be taken up and explored at a deeper level from analysis. Throughout my discussion I consider works by other authors that add to my discussion, whilst opening up possibilities for future lines of enquiry.

The Construction of Family and Whānau as *'Risky'*

An analysis of the relations between family and whānau and the provision of mental health services in the community identified discourses problematising family and whānau through binary 'negative' and 'positive' constructions. These discourses have acted to limit, constrain, and provide possibilities for their involvement in service provision and iterations of *consultation*. In this thesis, I have argued that early constructions of family and whānau (explored in Chapters Five and Six) shaped the notion of *consultation* as it formally materialised as Section 7A in the MHA, 1992. More contemporary constructions of family and whānau have supported shifts within the notion of *consultation* providing nuances within practices over time, such as the interplay between discourses of *recovery*, *risks*, and confidentiality (see Chapter Seven).

Association between *risks* and *community care* continually resurfaced through texts from the 1950s up until present times. Although the notion of *community care* has remained generally static as a signifier of 'supporting persons with mental illness and distress in community settings', notions of *risk* have constantly shifted in significations, materialising as potential *risks* to the concept and strategy of *community care* practices. In this first argument of my discussion, I extend the notion of '*risks*' situated within the *patient* by contending that '*risks*' have been situated within family and whānau. I argue that situating *risks* within family and whānau has made possible the construction of subject positions authorising disciplinary actions from the State through psychiatric discourse. I also note internal constructions, where family and whānau have constituted themselves through an uptake of *risk* discourses. I begin this argument through reviewing the notion of *risks* situated within the *patient* and within populations, drawing from research literature and government texts, and then in drawing from my analysis to situate *risks* within family and whānau. Finally, I consider the implication of constructing family and whānau as '*risky*' for future iterations of *consultation*.

Situating Risks Within the Patient

> Certainly, if in ever so small a degree there is to be a stamping out of Insanity, we must act on the principle, better let the individual suffer, than run the risk of bequeathing a legacy of Insanity to the next generation.[241]

---

[241] Bucknill, J. C., & Tuke, D. H. (1879). *A manual of psychological medicine: Containing the lunacy laws, the nosology, aetiology, statistics, description, diagnosis, pathology, and treatment of insanity: With an appendix of cases* (p. 63). J. & A. Churchill.

On contemplating the appropriateness of marriage for females diagnosed with insanity, 19th century physicians Bucknill and Tuke situated madness as a 'thing' within the body, that, through procreation, had the possibility to regenerate and proliferate within society. The notion of madness and its constructions as mental disorder and mental illness as an internal defect of the body has dominated psychiatric discourse since its inception, providing the conditions for acting on bodies. In 'Madness and Civilisation', Foucault (1989) described the asylum as a place for segregating bodies where practices of confinement enabled the examination and repression of madness.

Noting the association of danger with madness through the concept of the 'dangerous individual', relations between psychiatry and law formed to justify confinement through the notions of protecting society from the *madman* and protecting the *madman* from 'himself' (Foucault, 1994a). Although practices of confinement shifted during the rupture of deinstitutionalisation to become temporary in nature, possibilities for compulsory hospitalisation have continued, signifying the *risk*s of the 'dangerous individual' to themselves and to others. Visible as a foundational concept within the mental health Acts of New Zealand, guidelines to the Acts, and thus shaping practices, the notion of situating *risks* within the *patient* is made possible through the concepts of potential harm to self and to others.

The notion of the 'dangerous individual' prior to actual harm occurring, situates the potential of danger within the body. The construction of the '*risky individual*' as a person capable of future danger to self or others was noted by Rose (2010) as providing the conditions for governance based on the concept of mitigating future *risks*. For Foucault (1994h), relations of power inscribe identity onto the body, hence the '*risky individual*' "marks him by his own individuality, attaches to him his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him" (p. 331). Through the establishment of potential *risks* to self or others within the designation of the *mental health patient* identity, the body can be examined in its interactions with political and social events, mapping out identity from within psychiatric discourse (Jager & Perron, 2023). For example, the body, constructed as an internal defect through the identity of diagnosis and attachment to historical and potential *risks*, is examined in its interactions with the clinician, exampled through acceptance of medication, attendance of appointments, engagement in tools shaping service provision such as *recovery,* and events considered *risky*.

Pastoral power, benefitting from the intimate relations between the *patient* and clinician, seeks to personalise the body through “a knowledge of the conscience” (Foucault, 1994h, p. 333); an individualising power gained from confession from the person or others, such as family. Providing the conditions for monitoring, examination, and a hierarchal judging gaze (Foucault, 1977), the constitution of the ‘*risky individual*’ functions to shape conduct and diminish the ‘*risky individual*’ subject. Language normalising the notion of the ‘*risky individual*’ is found in that which aims to make visible and reduce; *risk factors*, *risk formulation*, and *risk management plans*. These conceptual strategies which, when appearing in text such as the ‘Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act, 1992’ [MHA, 1992][242] legitimises practices of commitment, restraint, and seclusion of the ‘*risky individual*’, strengthening its identity as ‘*risky*’. The production of the ‘*risky individual*’, where *risk*s are an inherent trait of the *patient*, has been argued in research as maintaining the domination of psychiatric discourse in mental health service provision (Domingue et al., 2023; Holmes & Gagnon, 2018), but also provides opportunities for resisting *risk-averse* practices through challenging structures and processes (Johnston et al., 2023; Slemon & Dhari, 2024; Slemon et al., 2017).

Situating Risks Within Populations

In this thesis, I argue that the notion of the ‘*risky individual*’ extended onto populations, exampled through situating *risks* within Māori. This occurs such as through statistics employed in political texts to address overrepresentation of Māori for specific ‘problems’, like rates of mental illness, suicide, and compulsory hospitalisation.[243,244,245] Inscribing Māori as an *‘at-risk-population*’ through an *equity* lens (ChapterSseven), demonstrates possibilities to situate discourses of *risk*; to fix and totalise a population for governance strategies from within a deficit framework (Foucault, 1994h; Houkamau et al., 2016). The use of comparing statistics has normalised the notion of Māori as *at-risk* and more ‘vulnerable’ than non-Māori through life events and lifestyle choices.

---

[242] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

[243] Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012-2017*. http://www.health.govt.nz/system/files/documents/publications/rising-to-the-challenge-mental-health-addiction-service-development-plan-v2.pdf

[244] Ministry of Health. (2023). *Office of the Director of mental health and addiction services: Regulatory report 1 July 2021 to 30 June 2022*. Author. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-regulatory-report-1-july-2021-30-june-2022

[245] O'Dea, T., & Tucker, S. (2005). *The cost of suicide*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/thecostofsuicidetosociety.pdf

Higher rates for Māori for smoking, hazardous drinking, obesity, and food insecurity,[246] as examples, provides a totalising gaze of Māori as more 'flawed' than non-Māori.

Situating *risks* within the Māori population through comparable statistics in compulsory assessment practices—with Māori more likely to be assessed and be subject to treatment orders; more likely experience seclusion and longer times within seclusion; and more likely designated as 'special' and 'restricted' *patients*[247]—constructs the identity of Māori as '*riskier*' than non-Māori. Drawing from assimilation discourse, defining Māori identity as '*riskier*' provides the conditions to stigmatise Māori within the normalisation of Western discourse and practices. Relations between stigma and institutions then provides possibilities for actions to de-stigmatise, such as through the concept and strategy of 'Whānau Ora' (Chapter Seven) and its focus on providing services for Māori by Māori (Lavin & Barnes, 2020).

Situating *risks* within populations has the potential to exaggerate those *risks* through relations of power/knowledge stemming from dominant discourses, such as European notions of health. Houkamau et al. (2016), in research, argued that the labelling of Māori as *high-risk* provides stereotypes that compound problems through confirmation bias from clinicians, and the potential self-constitution of Māori as *higher-risk* from within this biased gaze. Through an uptake of this label, Māori identity risks becoming a 'self-fulfilling prophesy' in response to discrimination and racism from health service providers using a European, colonising gaze. The internalisation of racism, such as feelings of shame and unworthiness, embarrassment and guilt, arising from perceptions and realities of being judged for lifestyle choices, functions to censure Māori lifestyles and values as problematic through association with *risks*, and can function to disconnect Māori from accessing services (Houkamau et al., 2016; Walker et al., 2023). In this discussion chapter, I contend that the notion of *risks* situated within the *patient* and populations can also be considered to reside within the family and Māori whānau. Drawing from my analysis in the previous three chapters, I argue that situating *risks* in

---

[246] Ministry of Health. (2023). *Annual data explorer 2022/23: New Zealand health survey* [Data file]. https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/

[247] Under Aotearoa New Zealand law, people who have been charged with committing crimes while severe mental illness was influencing their judgement may be treated in a secure mental health facility instead of going to prison. These people are given 'special patient' status. Ministry of Health. (2023). *Office of the Director of mental health and addiction services: Regulatory report 1 July 2021 to 30 June 2022* (p. 35). Author. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-regulatory-report-1-july-2021-30-june-2022

family and whānau has significantly shaped and continues to shape practices of *consultation*.

Situating Risks Within Family

In my analysis of the possibilities for initial family involvement in mental health service delivery during practices of deinstitutionalisation, the notion of *risks* within the family emerged as an unnamed yet growing presence from the 1950s. With psychiatry shifting its interests from the *patient* towards the interactions between the *patient* and family members, life events associated with the developmental life cycle of the family provided the conditions for identifying stress as a precursor to the development of mental illness. A gaze on family through psychoanalytical research on family interactions during the 1950s and 1960s (cf. Friedman & Friedman, 1970; Nuffield, 1954; Wolman, 1961) 'confirmed' assumptions from early physicians (cf. Barlow, 1845; Bucknill & Tuke, 1879) that mental illness was transmittable through genetics and the conduct of parents and family members.

Relations of power between psychiatric, psychoanalytical, and public health discourses marked family as a source of mental illness, thus situating *risks* of illness development within the family unit. In Chapter Five, I identified relations of power negatively constructing family as sick, deviant, stigmatising, and untrustworthy, limiting family from positions supporting the deinstitutionalisation of persons leaving large psychiatric hospitals. As with the *patient*, the family became an object for examination, mapping out its identity from within psychiatric, psychoanalytical, and public health discourses (the political); and through practices, such as home visits from the public health nurse and general practitioner visits (to identify events). The notion and construct of the '*risky individual*' was replicated into the '*risky family*', marking its identity as potentially causative for illness development through notions such as neglectful and anti-social parenting styles, lifestyle choices (e.g., alcohol and drug use), and problematic emotional relations between spouses. The formation of the day hospital became another site for the identification of the '*risky family*' enabling disciplinary tactics to shape relations between family members through the mechanism of rehabilitation.

Anti-psychiatry discourse challenging the dominance of a biomedical gaze within the construction of mental illness continued to signify family as *risky*. Madness, considered a 'social' event occurring through psychological and social environments, strengthened the notion of the problematic family, through providing further possibilities to associate *risk-of-illness* development from within family relations. The 'truth' of the family as a *risky* entity emerged in the early era of *community care* practices, shaping its relations with clinicians and service providers into subservient positions for governance strategies. Constructing family as deviant and sick provided limits within power relations, such as (future) iterations of *consultation* arising from notions of the family as (un)reliable and (ir)responsible. If information from family could not be trusted, the need for consulting could be questioned. *Risks* were situated within the family through potential 'harm' to itself and the *patient*, and externalised through *risks* of working with family. The trustworthiness of the '*risky family*' was questionable; hence, a condition for its relative exclusion from *community care* practices until the political rupture of neoliberalism.

In Chapter Six, I identified the emergence of binary (unhelpful/helpful) positions for family, and other ways to situate *risks* within the family. Within a growing neoliberal environment placing emphasis on personal responsibility (and thus a reduction of State responsibility), the 1980s witnessed alternative constructions of family as a support system and possible strength alongside constructions of sick and deviant. An interplay between neoliberal political values, the emergence of rights discourses, and a greater focus on the *risks* from persons diagnosed with a mental illness, supported constructions of family as a support through the *carer* position. A perceived lack of rights for *carers*, witnessed through critique of supports and resources from mental health service providers, situated alternative *risks* within the family through the notion of *burden of care*. As well as critiquing levels of support from service providers, *burden of care* was employed by several organisations to question the lack of rights for family, and the expectations of caring falling on female members of the family.

For a brief period in the late 1980s/early 1990s advocacy from *carer support groups* constructed family, and especially female members, as an *at-risk-population* from notions of *carer burnout*, and lack of family rights in comparison to *patients' rights*. Family had, by this time, self-constituted itself as expert knowledge on the lived experience of mental illness, following a similar notion from persons experiencing illness. Advocacy of this notion was employed to highlight *risks* to the successful functioning of *community care* if ignored. With family-as-experts potentially constrained by self-constituted *burden of care* and a lack of agency within the service-family relationship, a shift from service providers to accommodate family agency and expertise was made possible.

From my analysis, I argue that the concept and strategy of *consultation* as Section 7A emerged through situating *risks* within the family in multiple ways, inviting possibilities for *risk management* strategies through psychiatric and governmental expertise. Iterations of *consultation* noted in Chapter Five, such as the provision of information about the *patient* from the family to services, and later, the provision of information on the *patient* from the clinician to family (Chapter Six), formed initial relations between clinicians and family aiming to diminish *risks* within the *patient*-clinician-family relationship.

The formation of *family-inclusive mental health service provision* and the position of *partnership* in the late 1990s, responsibilising family into caring positions, identified family as impacted by mental illness, enabling direct interventions onto family. This was not a new thing, as education on stress from the 1950s and rehabilitation clinics during the 1970s functioned as interventions to shape family conduct. However, practices of psychoeducation in the 1990s functioned to 'upskill' the family in psychiatric discourse to specifically manage *risks*, such as illness relapse, and *burden of care*. Despite multiple challenges to the domination of *risk* discourses within mental health practices, identified in Chapter Seven such as strengths-based philosophy, *positive risk-taking*, *recovery*, and *wellbeing*, *risk* discourses have remained prevalent in shaping service provision and contemporary practices of *consultation* through ongoing constructions of family as '*risky*', with functions of managing *risks* within the family as well as the person diagnosed with mental illness.

Situating Risks Within Whānau

So far in this discussion, the notion of situating *risks* within family has nominally considered cultural differences impacting *consultation*. As noted above, family had constituted itself as an *at-risk-population* through *carer* organisations critiquing a lack of rights and *burden of care*. I have also discussed how Māori was constructed as *an at-risk-population* through statistics and comparison with other populations through European notions of health. I now consider the construction of '*risky whānau*'. In Chapter Five, my analysis identified the construction of family parenting and extended family systems for non-European populations as particularly *risky* from a psychiatric gaze. The formation of relations between mental illness and crime signified a form of deviancy arising from non-European ways of thinking and doing, including the notion of collectivist cultural values and practices.

Associations between extended family systems and crime, endorsing Western, nuclear iterations of family, supported constructions of *risk/dangerousness* situated within Māori individuals and whānau. Notions of Māori dangerousness, such as through the highly critiqued 'Māori warrior gene' which made claims that Māori were predisposed to violence and criminality through genetic studies,[248,249] and media, such as 'Once were Warriors'[250] depicting family violence, produced and normalised the '*risky Māori individual*' and '*risky whānau*'. Significant events, such as the murder of the 3 months-old Kahui twins in 2006, with regular reporting surfacing in media from 2006 until 2012 depicting a '*savage Māori welfare underclass*' (Hackell, 2016), recirculated associations between Māori beneficiaries and violence through child abuse. The dominance of negative constructions of certain Māori groups in media and service provision subjugated alternative discourses, as noted by Hook (2009):

> An explanation for the high conviction rates of Māori for violent crimes is to be found not in his nature but elsewhere perhaps such as in his victimhood arising out of 160 years of colonization or in how the justice system deals with people whom most of its Eurocentric white administrators perceive as being excessively violent.[251]

In a similar vein, 'Once were Warriors' depicted family violence within the background of loss of traditional ties to cultural heritage and values through institutional racism and colonialism (Thornley, 2001). For the highly recirculated murder of the Kahui twins, deprivation, disadvantage, and the lack of support structures for marginalised populations has been suggested by Hackell (2016) as discourses constrained by neoliberal political agendas.

Depiction and critique of Māori as 'other' continues to reproduce Māori and other non-European populations in colonised countries as stereotypical constructions that function to constrain and limit (Wall, 1997). Through the pathologisation of non-Western family practices, exampled through relations of neglectful parenting and crime (Chapter Five) and '*whānau secrets*' (Chapter Six) signifying whānau with notions of deviance and

---

[248] Hook, G. R. (2009). "Warrior genes" and the disease of being Māori. *MAI Review, 2,* 1-11. https://www.journal.mai.ac.nz/system/files/maireview/222-1507-1-PB.pdf

[249] Perbal, L. (2013). The 'warrior gene' and the Māori people: The responsibility of the geneticists. *Bioethics, 27*(7), 382-387. https://doi.org/10.1111/j.1467-8519.2012.01970.x

[250] Duff, A. (1990). *Once were warriors*. Tandern Press.

[251] Hook, G. R. (2009). "Warrior genes" and the disease of being Māori. *MAI Review, 2,* p. 7. https://www.journal.mai.ac.nz/system/files/maireview/222-1507-1-PB.pdf

‘something to hide’, my analysis supplements research critique on the production of the ‘*risky whānau*’. I have also demonstrated in Chapter Seven that resistance to stereotypical constructions through concepts such as ‘Whānau Ora’ and *wellbeing* have drawn from Te Ao Māori (worldview, cultural practices, and values) to challenge the dominance of Western discourses totalising and subjugating Māori whānau within ‘inferior’ and ‘flawed’ positions.

The importance of taha whānau (the social environment) as a pou (pillar) of *wellbeing* within the model Te Whare Tapa Whā signifies whānau as a stabilising and strengthening concept that can function within the concept and strategy of *equity* and ‘Whānau Ora’ through adequate resourcing and tino rangatiratanga (self-determination and absolute authority). Yet, although promoted in contemporary policy[252,253] and the latest national inquiry,[254] these discourses remain marginalised within practices. With the ‘*risky family*’ as a reference point within *consultation*, possibilities to position ‘*riskier whānau*’ as being something worse through stereotypes of deviance and dangerousness from ‘otherness’ has the potential to limit Māori whānau *consultation*. Tensions between negative constructs and possible alternatives of whānau and family have important implications for *consultation* practices as discussed below.

Worse Than Criminals: Constructions of ‘Risky Family and ‘Riskier Whānau’ Within Consultation

I contend that the construction of family as *risky* and whānau as potentially *riskier* has had, and continues to have, significant implications for *consultation*. Situating *risks* within family and whānau as sick, deviant, stigmatising, and untrustworthy has acted as exclusionary mechanisms for early iterations of *consultation*, limited to the passing of information between family and clinicians during early practices of *community care*. Constructing non-European whānau in relations with criminality and dangerousness has provided further constraints on the notion of *consultation* through stigma. As a counter-weight, the subjugation of family and whānau within a growing neoliberal environment, and the emergence of rights discourses, provided the conditions for resisting an imbalance in power relations through the notions of familial and cultural expertise. This acknowledgement was witnessed through the promotion of family and whānau in

---

[252] Ministry of Health. (2023). *New Zealand health strategy*. Author.

[253] Ministry of Health. (2023). *Pae tū: Hauora Māori strategy*. Author.

[254] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali’i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

decision making within the planning and delivery of services and the uptake of Te Ao Māori (worldview and cultural practices). Even if potentially tokenistic, the inclusion of family and whānau through familial and cultural expertise provided the conditions for Section 7A to emerge as statutory guidance for family and whānau agency within compulsory assessment and treatment. However, a monocultural view of the family as an individualistic structure (even within the premise that the *patient* identifies who family is) made visible through the *principal caregiver* has constrained family agency through the notion that family is of 'one opinion'. This argument is continued below in the next section on *consultation* as a tool for colonisation.

Resisting a 'one opinion' through extended family and whānau incorporating iwi, hapū, and community organisations into an iteration of *consultation* could better support family and whānau in decision making through providing other potential resources into *consultation* processes. Other resources and opportunities beyond the generic binary of immediate responsibilities witnessed as hospitalisation (clinical) or non-hospitalisation (family and whānau) may provide the conditions for better outcomes for the person experiencing compulsory assessment and treatment, their family and whānau, and mental health services through extended opinions and greater choice of actions.

Potential risks of extending out the players involved in *consultation* may increase time, especially contextual to differing opinions; however, possibilities for other options beyond the environments of hospital or home or the general community for persons requiring greater input may support better long-term outcomes. Although other options of support exist, such as Kaupapa Māori service provision, these services remain marginalised through their lack of visibility and lack of resources (cf. Kopua, 2019). More recent developments, such as the notion of crisis respite, are few and far between with minimal research as to the efficacy (cf. Magill et al., 2022). I argue that if greater options are available, *consultation* may shift from a discussion on 'hospital-or-home' to better reflect the concepts of *recovery*, *equity*, *wellbeing*, and tino rangatiratanga (self-determination and absolute authority).

Constructions of family as a support system and a strength, as *partners* and *facilitators of recovery*, and as 'Whānau Ora', emerged during and post the inclusion of *consultation* as Section 7A within the MHA, 1992. Although these positions have challenged and resisted negative constructions of family and whānau, situating potential *risks* within family and whānau have continued, providing the conditions to constrain and limit involvement in *consultation* at the discretion of clinicians. A lack of oversight, and apparent accountability (beyond statistical recording)[255] maintains family and whānau *consultation* practices within the dominion of the *responsible clinician* and thereby psychiatric discourse. I argue that recent critique of compulsory assessment practices as coercive and controlling arising through *risk-averse* practices,[256] are able to dominate in part through underlying assumptions situating *risks* within family and whānau.

(Re)producing historical socio-cultural *risks* and potential *risks* within family and whānau, drawing from notion of deviance and criminality, continue providing the conditions for subjugation and exclusion of family and whānau within *consultation* practices. Family and whānau have been advocating for more inclusion in iterations of *consultation* since the 1980s.[257,258,259] Yet, as the following quote from 'He Ara Oranga' suggests, historical notions of family and whānau deviancy continues to function within the present:

> The moment that mental health became involved in his treatment, we were isolated from him. …As parents we were treated worse than criminals (Family member of service user).[260]

Inclusion of the concepts of *partnership* and 'Whānau Ora', as examples, provides possibilities for future iterations of *consultation* to address the power imbalance arising from the hegemony of psychiatric and clinical discourses.

In my first argument within this discussion chapter on situating *risks* within family and whānau, I have identified the notions of the '*risky family*' and '*riskier whānau*' limiting,

---

[255] Ministry of Health. (2023). *Office of the Director of mental health and addiction services: Regulatory report 1 July 2021 to 30 June 2022*. Author. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-regulatory-report-1-july-2021-30-june-2022

[256] Health and Disability Commissioner. (2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Author. https://www.hdc.org.nz/our-work/mental-health-addictions/monitoring-and-advocacy-report-of-the-mental-health-commissioner-2020/

[257] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services* (p. 24). Ministerial Inquiry to the Minister of Health.

[258] Ministry of Health. (2006). *Review of the Application of Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author. https://www.health.govt.nz/system/files/documents/publications/review-application-of-section-7a.pdf

[259] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction.* Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

[260] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction* (p. 46). Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

constraining, and providing opportunities for inclusion in mental health service provision and iterations of *consultation* including Section 7A in the MHA, 1992. Family and whānau inclusion in mental health service provision and practices, such as *consultation*, have, however, remained contentious throughout *community care* practices, as family and whānau have been persistently constructed and positioned within *risk* discourses. Making visible these constructs provide possibilities to think otherwise about family and whānau involvement in mental health service provision and practices such as *consultation*.

The distinction made in this discussion between family and whānau as '*risky*' and '*riskier*' is taken up in my next argument within this chapter. Drawing from an article by Cohen (2014) arguing that psychiatry has functioned as a tool for colonisation, I argue that, through my analysis, Section 7A *consultation* can be considered a tool for colonisation through limiting collective agency within the Act, as witnessed through the position of *principal caregiver*.

Section 7A: Shaping Consultation Through a Colonial Gaze

In the previous discussion, I have argued that situating *risks* within family and whānau provided the conditions for managing *risks* through psychiatric and governmental expertise. Section 7A *consultation* can be considered a strategy for managing *risks* through enabling the identification of *risks* through a gaze on the family, and through confession (Foucault, 1977, 1978). *Risks* situated within the *patient*, such as harm to self or others and family, such as *burden of care*, can potentially then be managed through a range of responses including medication, hospitalisation, increasing supports, and shaping conduct through tactics like psychoeducation.

Risks can also be identified from family through a gaze on clinicians and service provision within *consultation*, drawing from notions of family expertise and rights, and providing opportunities for force and resistance within the family-clinician experience. In my analysis I have identified that the possibilities for *consultation* emerged through negative constructions of family and whānau (sick, deviance); and resistance from family, whānau, and others to these constructions (expertise, support systems). Intersections between responsibility, *risks*, and rights emerged in relations with psychiatric discourse, shaping *consultation* within Western notions in the 1990s.

Critique from Māori resisting Western notions of expertise in mental health service delivery emerged more visibly from the 1980s, through taha Māori (Māori perspective) and mātauranga Māori (body of knowledge emerging from Polynesian origins) and through reports and inquiries.[261,262] The increased presence of Te Ao Māori (worldview) to tackle the dominance and effects of Western discourses, such as racism, has highlighted social injustice, deprivation and powerlessness through the subjugation of Te Ao Māori (worldview and cultural practices) leading to inequities in service outcomes.

My analysis has added to scholarship situating Māori expertise as relational with the notion of whanaungatanga (cultural kinship and connection) central to achieving *equity* in healthcare service delivery (cf. Komene et al., 2024; Pene et al., 2023; Wilson et al., 2021). I now provide focus on Section 7A *consultation* as emerging at a time when Indigenous perspectives of health were significantly constrained through the dominance of Western discourse. The notion of *biculturalism*, for example, promoting a Māori perspective and opportunities for agency, was, however, constrained within practices through reduced resource allocation, advancing non-Māori practices within the notion of *bicultural partnership* (MacDonald, 2022; Sibley et al., 2005).

Therefore, I argue that Section 7A *consultation* emerged and continues to function as a colonising tool through the exclusion of Indigenous perspectives of health from within the structure and processes of *consultation*, even with the recognition and inclusion of concepts such as whanaungatanga within the latest guidelines to the mental health Act.[263] This discussion begins by situating Indigenous health practices as a threat to European colonisers, and the use of psychiatry as a tool for colonisation drawing from other authors. From my own research, I then argue how Section 7A *consultation* functions as a colonising tool through its structure and processes, with implications for family and whānau, opening up the discussion to consider future possibilities for *consultation*.

---

[261] Mason, K. H., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services* (p. 24). Ministerial Inquiry to the Minister of Health.

[262] Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients.* http://www.moh.govt.nz/notebook/nbbooks.nsf/0/2DC94A246D93272C4C2565D7000DDA26/$file/Mason%20Report.pdf

[263] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

The Threat of Indigenous Health Practices to Colonialism

In Chapter Six, I identified tensions between Māori and Western understandings of health constraining Māori whānau inclusion in mental health service provision and functioning as resistance to monocultural service provision. My analysis highlighted institutional barriers, including Western education systems, as limiting Te Ao Māori (worldview and cultural practices) within the delivery of services, adding to research scholarship in this area (cf. Durie, 1985; Graham & Masters-Awatere, 2020; Jeffery, 2005; Wilson & Baker, 2012).

Barriers acting as constraints on Te Ao Māori cultural practices includes positioning Māori as 'other' through a colonial gaze; thus, comparable to Western practices. Law is one tactic that was used to compare European and non-European practices enabling 'othering' and functioning to repress and control. The Tohunga Suppression Act 1907 is a prime example, which used the 'othering' of Māori practices through hierarchal examination and judgements to position Māori understandings of health as primitive, deficient, and dangerous (Paterson, 2011; Stephens, 2001; Woodard, 2014).

The notion of health as comprising physical, mental, spiritual, whānau relations, and connection to land and the environment (cf. Durie, 1985) signified deviance from a colonial gaze as not 'fitting' within Western biological perceptions of health and illness. The notion of tohunga (expert) as a person skilled in leadership, healing, and other cultural practices and values of Te Ao Māori was repositioned in the Act as a fake and dangerous entity misleading Māori people (Hokowhitu et al., 2022). Māori practices aiming to improve health were represented as harmful to Māori health and a potential threat to the assimilation of the Māori population into European cultural norms (Cohen, 2014).

In Chapter Five, my analysis noted how European anthropological research drawing from psychiatric discourse positioned non-European populations as primitive and deviant through engaging in non-European ways of thinking and doing, including notions of 'health'. My analysis provided examples of Western thinking of Māori and Pasifika populations as 'primitive, deficient and dangerous' through research,[264,265] circulating notions of whānau and extended relationships in associations with deviance

---

[264] Kelly, R. (1973). Mental illness in the Maori population of New Zealand. *Acta Psychiatrica Scandinavica, 49*(6), 722-734. https://doi.org/10.1111/j.1600-0447.1973.tb04461.x

[265] Gluckman, L. K. (1977). Clinical experience with Samoans in Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 11*(2), 101-107. https://doi.org/10.3109/00048677709159545

and crime. Parenting skills and living arrangements were exampled as providing the conditions for 'defective' personality traits, pathologised through a psychiatric gaze. Māori cultural practices (exampled in these research articles) resisting non-European ways of thinking and doing were noted as a potential threat to Western discourses and European social order (Keller, 2001). This notion was taken up in an article by Hokowhitu et al. (2022) noting Indigenous tohunga (expert, see above) was perceived by early European colonisers as a form of resistance to European knowledge systems and a threat to the imperial power of the settlers. From this gaze, the dehumanisation of Māori through subsequent positioning of Te Ao Māori (worldview and cultural practices) as primitive and irrational provided the conditions for assimilation through subjugation; justifying suppression of the threat of Indigenous health knowledge and practices as ultimately beneficial to Māori.

I argue that historical perceptions of Indigenous health knowledge as a threat to Western understandings and practices of health continues to function today. Critique of breaches of Te Tiriti O Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in mental health service delivery were exampled in 'He Ara Oranga' the national inquiry into mental health and addictions[266] through overrepresentation of Māori in compulsory assessment and treatment, restraint, and seclusion, signifying a lack of Māori agency in political and institutional spaces. The formation of Te Aka Whai Ora (the Māori health authority) as a distinct organisation within the health system to partner Te Whatu Ora (Health New Zealand), and its aspirations to increase tino rangatiratanga (self-termination) and mana Motuhake (the right to self-govern) to improve the health of Māori, was disestablished within 2-years of operation. Its disestablishment has been consistently reported in the media as politically motivated and damaging for Māori health and a potential breach of Te Tiriti o Waitangi (Baker, 2024; Rolleston, 2024; "Te Aka Whai Ora disestablishment 'damaging' For Māori health equity," 2024). Its short-lived existence and potential inability to demonstrate its effectiveness as an organisation prior to disestablishment could signify a contemporary event where resistance to Western health discourses through the promotion of Indigenous health knowledge and practices is perceived as a threat. Suppression of mana Motuhake (the right to self-govern) through the disestablishment of the Te Aka Whai Ora (the Māori health authority) is also reminiscent of historical beliefs from

---

[266] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

colonising races that the colonised are incapable of governing themselves (Cohen, 2020). In the next section, I argue that psychiatric discourse has been used to counter threats through tactics that suppress specific populations and promote assimilation of Māori through colonising processes.

Psychiatry as a Tactic of Suppression and Colonisation

In situating madness and the development of Western medical structures within socio-political and technological power relations, Foucault (1989, 1994a, 2011) made visible the potential social implications of psychiatric practices arising from political motivations (Keller, 2001). For example, research has situated psychiatric classification systems as maintaining patriarchal dominance, enabling the suppression of females through the pathologisation of the female body (Devereux, 2014; Hirshbein, 2010; Ussher, 2017). The notion of feminism itself has been represented as mental illness, through terminology suggesting 'fanatical' and 'delusional' thinking (Zier, 2021). In Chapter Five I identified the depiction of 1970s suburban females as more 'vulnerable', an inherent 'weakness' of the 'sex', leading to illness development from the stress of intimate relationships and disconnect with imposed 'suburban' gender roles. My analysis noted forms of suppression from within intimate relationships and psychiatric discourse through the pathologisation of being female and (mis)diagnosis, as discussed by Ussher (2017). I have shown that the depiction of female vulnerability, in relations with the perpetrating partner, expanded psychiatric practices into gender, naturalising *community care* in another form.

Critique has also made visible associations between psychiatry and attempts to supress male conduct considered as deviant. Male homosexual practices originally classified as "sociopathic personality disturbance" in the first 'DSM' (American Psychiatric Association, 1952), shifted notions of homosexuality as 'sin' to 'mental disorder' providing conditions for 'treatment' to suppress homosexual feelings and practices (McHenry, 2022; Szasz, 1967). In my analysis, representations of the faulty male, such as the "emotionally defective" husband as a cause of mental illness in their wives,[267] provided opportunities for psychiatric interventions to 'save' and thus govern the family. These examples equate the potential for a 'political' function of psychiatry, addressing potential threats to traditional structures and associated value and morality-based

---

[267] One in five mentally ill. (1971, March 31). *Press*, p. 2.

systems, as well as maintaining governance to social changes, such as through notions of rights.

Relations between psychiatry and race have also emerged as critique on colonising practices subjugating the knowledge and cultural practices of Indigenous populations through associations with deviance and mental illness (Butts, 1979; Cohen, 2014; Cohen, 2020; Dixon et al., 2014; Dupuis-Rossi, 2021; Keller, 2001; Moewaka Barnes & McCreanor, 2019; Walsh, 2022).

Functions of colonisation as physically taking over a territory, its peoples, and resources, can also be considered as an ongoing strategy of cultural and political domination. The construction of the colonised as ‘other’, justifying enduring authority within institutional structures; ‘*post-colonial rule*’. Ideologies and practices naturalising Western discourses thus function to silence the knowledge, experiences, and practices of those being colonised (Cohen, 2020). Signifying Western discourses as a form of ‘truth’, and the ‘other’ as ‘false’ (see above discussion on tohunga) has supported representations of the ‘native’ with ‘primitive uncivilised’ thinking.

The notion of the ‘primitive’ as being too unsophisticated to experience mental illness had been used to explain low rates of mental illness in the Māori population pre-1950s, as within other colonised populations (Cohen, 2014; Keller, 2001). This thinking changed, as suggested by Cohen (2014), from the 1950s, coinciding with significant migration of Māori from rural to urban centres. An “increased visibility of Māori within the urban environment together with the increased political activism among the ‘young Māori’ frightened Pākehā society” (Cohen, 2014, p. 332), shifting perceptions of Māori from ‘passive’ and ‘simple’ towards representations of ‘antisocial’ and ‘dangerous’. A simultaneous surge of (mis)diagnosing young Māori males with schizophrenia was argued by Cohen as managing the threat of consciousness and resistance to Western domination, a practice replicated across colonised countries (cf. Keller, 2001).

Drawing from notions of the ‘Māori savage’ in historical relations with violence, death, and disease, Western knowledge, values, and practices were historically constructed as superior, enabling the colonisation of Māori health (Hokowhitu, 2014). The modern use of statistics depicting Māori as more susceptible to developing mental illness ‘confirms’ Western superiority through the notion of the ‘*faulty/risky population*’ in need of psychiatric interventions. My analysis supplements arguments that the notion of

Western superiority continues to play out within contemporary health service delivery (cf. Cohen, 2020; Hokowhitu, 2014; Hokowhitu et al., 2022).

In Chapter Seven, and earlier in this discussion chapter, I identified different tactics of legitimising psychiatric discourses through representations of Māori as '*riskier*' within comparable statistics and the concept of *equity*. The "logic of disparity" (Hokowhitu et al., 2022, p. 108), which defines the problem within the 'other' (and not a condition emerging from colonisation itself) has functioned as a tool to authorise actions on Māori from within Western paradigms. The assimilation of non-Western discourses (exampled in Chapter Seven with Te Whare Tapa Whā) provides possibilities to depict services as progressive and culturally responsive, yet maintain Western hegemony, through oversight of resources and authority within decision making at the level of the State. Constructions of Māori from Western paradigms as '*riskier*' and '*faulty*' and the assimilation of Māori knowledge has enabled a continuation of political and cultural colonisation in the sphere of health justified by the gaze of psychiatry itself. I now extend my discussion onto the specifics of *consultation* as Section 7A drawing from the above notions of Indigenous health beliefs and practices as a threat to Western notions of superiority, and the use of psychiatry as a tool for colonisation.

In the following discussion I claim that *consultation* Section 7A, as it materialised in 1999 in the MHA, 1992, has functioned as a tactic of colonisation through limiting whānau collective agency. I begin the discussion on possible meanings and differentiations between family and whānau, and possibilities to operate within *consultation* through the construct of the *principal caregiver* position. I then consider the influence of the recent increase of Te Ao Māori (worldview cultural practises) on future iterations of *consultation*. To conclude I provide some thinking about the potential future use of material found in this thesis and my dual role of researcher and clinician.

Europeans' Notions of Family

The word 'family' has links with the 15th century Latin term 'familia' that represented the 'householder' and members of his household including kin, blood relatives, and servants (Rothausen, 1999). According to Greif (2006), medieval Europe witnessed the emergence of smaller family units through religious doctrine, discouraging the expansion of families through laws that undermined the structure of kinships. European family structures more likely represented the immediate members of parents, children, close relatives, (potentially servants), and not kinship/clanship which had been previously promoted by Germanic colonisers. Small family units, comprising of a husband, wife, and children, often denoted as the ‘nuclear’ family in Western society, was typically patriarchal; therefore, as with the original meaning of ‘familia’, retains the notion of male hierarchy as the householder in the majority of ethnic cultures (Rothausen, 1999). Foucault (2003) noted a similar shift in the upper-class system from extended family systems to smaller units, though as a consequence of significant technological changes occurring in 18th century Europe:

> Until the middle of the eighteenth century the aristocratic or bourgeois family… was above all a sort of relational system. It was a bundle of relations of ancestry, descent, collateral relations, cousinhood, primogeniture, and alliances corresponding to schemas for the transmission of kinship and the division and distribution of goods and social status… What is now being constituted is a sort of restricted, close-knit, substantial, compact, corporeal, and affective family core: the cell family in place of the relational family. (p. 248)

The shift of family into smaller units linked in with notions of technological and social ‘advancement’ provided the conditions to associate the notion of the nuclear family with ‘progression’ and, therefore, potential ‘superiority’ to relational collectives of people. This idea can be seen within modern, non-traditional, or contemporary forms of family in Aotearoa New Zealand that retain nuclear forms, such as non-heterosexual couples co-habituating and those that challenge nuclear forms, such as communal living as gangs.

Although non-heterosexual relations as family in Aotearoa New Zealand has faced oppression and critique (cf. Atmore, 1995; Surtees, 2011; Taylor, 1977), law changes permitting non-heterosexual relations and marriage has sanctioned these non-traditional nuclear forms of family. Assimilation of non-traditional forms of family into society, such as this example, has been depicted as ‘progressive’ through association with human rights (see Brickell, 2022; Christie, 2009). Forms of communal living, including those labelled as ‘gangs’, where unrelated individuals share resources and similar values, provide internal support, protection, and social belonging (Hilder et al., 2018; White, 2009) have, since conception, experienced significant critique and attention from within the surfaces of politics and law. Relations constructed between gangs and criminal activities, through violence, drugs, and theft (see Breetzke et al., 2022; Gilbert, 2019), situates relational, extended forms of family as anti-social and dangerous. Of relevance to this thesis (and differentiation between family and whānau), 'gangs' in Aotearoa New Zealand have been typically portrayed through ethnicity. A focus on areas/towns in Aotearoa New Zealand with high Māori populations designated as problematic, and less focus on 'white gangs' (Lewis et al., 2020), presents further opportunities for stigmatising Māori through constructing links between 'whānau relations' and criminality and violence.

Constructions of Whānau

Whānau refers to giving birth and several understandings that represent or associate with meanings of family. Whakapapa whānau can mean a group of individuals with shared ancestry, in smaller forms and groups of extended relations (Metge, 1995; Moeke-Pickering, 1996). Pre-European forms of whānau were defined by Walker (2011) in Te Ara Encyclopaedia, as

> part of an interconnected world of tribe and sub-tribe, of the living and the dead. Although whānau members may live far apart or even overseas, their ties remain strong …Whānau is often translated as 'family', but its meaning is more complex. It includes physical, emotional and spiritual dimensions and is based on whakapapa. Whānau can be multi-layered, flexible and dynamic. Whānau is based on a Māori and a tribal world view. It is through the whānau that values, histories and traditions from the ancestors are adapted for the contemporary world. (paras1–2)

Notions associated with whānau, such as tribal relations and the position of tohunga (expert leader, healer) experience(d)[268] European categorisation as primitive, deviant, fake, and dangerous (see above discussion), providing the conditions of situating whānau as an inferior structure of familial relations comparable to smaller family connections constructed as European 'family'. Māori identity, including the meaning of whānau has, however, shifted towards smaller units, relative to colonisation, land confiscation, and mass migration to urban areas. According to Moeke-Pickering (1996), traditional social systems of support declined through urbanisation from the 1950s, impacting the underlying values that shape and form a sense of collective cultural identity. Opportunities for younger members to learn, socialise, and problem solve though observation and participation within the whānau diminished through the breakdown of larger structures (Metge, 1995). Relations constructed between the loss of

---

[268] Past and, arguably, present.

larger support structures through iwi and hapū, urban migration, and problematisations of the Māori population through health statistics and comparison, opens up these shifts within whānau to smaller units to other forms of criticism.

Whānau can also be used to denote other groupings and has been assimilated into European notions and practices. Kaupapa whānau represents individuals sharing a common bond not necessarily linked through ancestry; rather through sharing a geographical area or goal. More recently, whānau has been used to define households for statistical purposes, such as the collection of data to inform policy and service provision (Mckenzie & Carter, 2010). As with the term family, when used in less traditional means (such as by the rainbow community or to signify a sports club), whānau can be hard to define; more so, when dependent on the context of its use, why it is being used, who is using the term, and the audience (Walker, 2011). Its assimilation into English meanings and frameworks risks misinterpretation and possible abuse as a term (Moeke-Pickering, 1996) and, as argued below, provides the conditions for 'othering' and maintaining dominant power relations in practices such as *consultation*.

Potential differences between family and whānau from the above descriptions include notions of spirituality and connection with ancestors within the makeup of whānau, embedded within cultural practices of identity such as whakapapa. Within an introduction of personal identity, whakapapa provides a layering of Māori genealogy linking the person to ancestors and places through a Māori lens. As a term it holds a variety of meanings combining identity and cultural practices through history, stories, traditions, ancestral connections, and spirituality (Lindsay et al., 2022; Ngawhare, 2019)—an unlikely practice within 'European' introductions of identity.

As discussed in Chapter Seven, whānau is integrated into Māori understandings and practices concerning notions of health, drawing from whakapapa and relational cultural practices, with studies noting the significance of whakapapa to address *inequities* within health service provision and health outcomes whilst offering spaces for tino rangatiratanga (self-determination) (Kiyimba & Anderson, 2022; Lindsay et al., 2022; Mark & Lyons, 2010; Rolleston et al., 2022). Defining Māori through notions such as whakapapa can signify what it means to be Māori without using reductionist terms to categorise Māori through race, ethnicity, or culture (Gershon, 2008). Yet, within the focus of this thesis, with Māori more likely to be assessed and experience compulsory treatments, seclusion, restraint, and special patient status under the MHA, 1992 (Ministry of Health, 2023), conditions for defining Māori as 'other' and '*riskier*' through race, ethnicity, and cultural practices remain prevalent. In the following argument, I suggest that the formation of family and whānau *consultation* as Section 7A draws from Western discourses concerning familial norms in relations with psychiatric and clinical discourses. *Consultation* in this form is, therefore, more likely to suit Western notions of family and not Māori constructions of whānau, as exampled through the *principal caregiver* position.

Consultation: A Colonising Tool Within Psychiatric Discourse

The notion of the *principal caregiver*, as described in the most recent version of the MHA, 1992, Section 2, is interpreted as “the friend of the patient or the member of the patient’s family group or whanau who is most evidently and directly concerned with the oversight of the patient’s care and welfare”. I contend that the *principal caregiver* as constructed within the Act embodies European individualistic values through a hierarchical (“most evidently and directly concerned”), singular voice (“principal”), chosen (or not) by the person undergoing compulsory assessment and treatment processes. A singular voice is more befitting the notion of the ‘householder’; the head of smaller units of people disconnected from extended relational systems, commonly represented as the ‘nuclear’ family. In this sense, the position could be argued as an ongoing colonising strategy within the Act through marginalisation of what it means to be Māori as a collective entity in communication, and decision-making within the concept of tino rangatiratanga (self-determination).

In relations with health outcomes, with Māori more likely to experience compulsory assessment, hospitalisation, restraint, seclusion, and *special patient* status, the lack of whānau *consultation* from a tribal perspective within compulsory assessment and treatment processes may be a considerable influence driving these *inequities*. From this stance, I suggest that the notion of the *principal caregiver* as a function of the Act operates as a barrier and constraint for Māori whānau (and other collective cultures in Aotearoa New Zealand) through the domination of individualism within psychiatric and clinical discourses, and the marginalisation of other perspectives, explanations, resources, and potential outcomes, isolating whānau. ‘Isolation’ of family and whānau could be countered through collective decision-making enabling whānau greater involvement in the decision-making processes, not just the outcomes. Greater involvement of whānau as a collective in decision-making processes is argued by Tūpara (2009) as providing a greater sense of knowledge and understanding of processes, thereby providing opportunities for greater control and engagement.

However, promotion of whānau in decision-making processes provides possibilities for resistance. Potential constraints to the inclusion of multiple voices within compulsory assessment and treatment were raised at the time of suggested legislative change in 1999 and continue to play out within current service provision.

Towards the end of Chapter Seven, I identified text from the latest national inquiry 'He Ara Oranga' on the importance of cultural ties, including whānau, hapū, and iwi with *wellbeing*, as represented within Section 5 of MHA, 1992. The inquiry noted that consideration of cultural and ethnic identity was still lacking in psychiatric assessments and other practices of compulsory assessment and treatment, including decision making within tribunals and court proceedings. Several discourses at the time of proposed legislative change to introduce *consultation* in 1999 shaped the practice of *consultation* as a separate entity from Section 5's focus on cultural identity, enabling and potentially rationalising clauses to not consult with family and whānau.

In Chapter Seven I noted opposition from law (court and family judges) to augment the importance of cultural ties in Section 5 through *consultation*, employing reasoning through time constraints, practicality (such as timing requirements of the Act, and physical space to arrange and engage in *consultation*), and the potential disruption to proceedings relational to a sense of urgency. Time constraints on judges as a resource amongst other duties was also noted a reason limiting greater opportunities for *consultation* than was 'already practiced'. Other concerns of *consultation* as a statutory practice within the Act arose from privacy employing notions such as the 'sensitivity' of experiencing mental illness, the fluidity of relations with different family members, and overall, protection of the *patient* and their rights.

Vulnerability of persons from family and whānau was noted by some persons experiencing compulsory assessment and treatment highlighting *risks* from family contextual to *patient rights*. Drawing from these negative constructions of family and whānau, and 'practicality', discourses of exclusion shaped Section 7A *consultation* as the possibility to consult within individualistic forms restricted to certain Sections of the Act. Resistance to these negative constructions through an expansion of human rights discourses for family and whānau during the 1990s, alongside notions of consent, responsibility, and familial and cultural expertise (Chapter Six) made not consulting with family and whānau unthinkable. However, as a practice, its detachment from Section 5 has situated family and whānau *consultation* as a peripheral practice within the MHA, 1992, enabling the paradox of 'must consult' when 'reasonably practicable'.

The significant shift in recent years of acknowledging and assimilating Te Ao Māori (worldview and cultural practices) into policy and practices has provided the conditions to open up new possibilities for the delivery of mental health service provision and compulsory assessment and treatment. Integration of Te Ao Māori (worldview) has placed greater visibility of family and whānau as a cultural notion. The assimilation of relational ways of seeing the world (as with Te Whare Tapa Whā, and 'Whānau Ora' discussed in Chapter Seven) has been presented as tackling *inequities* in health outcomes and providing possibilities for tino rangatiratanga (self-determination and absolute authority).

Fashioning Māori as a cultural entity through the assimilation of Te Ao Māori (worldview and cultural practices) into service provision has made more visible Māori ways of being and doing. The incorporation of whanaungatanga into the 'Guidelines to the MHA, 1992[269] is one example of this. Human rights and *equity*, drawing from international treaties, such as the United Nations Declaration on the Rights of Indigenous Peoples and Te Tiriti o Waitangi, in relations with *wellbeing* have surfaced within critique of service provision[270] to signify greater emphasis on the inclusion of culture as progressive. However, as witnessed by the establishment and disestablishment of Te Aka Whai Ora (Māori Health Authority), possibilities for increasing Te Ao Māori, especially tino rangatiratanga (absolute authority), provides the conditions for resistance. The potential dangers of shifting service provision to better suit Māori risks alienating non-Māori and Māori in favour of Western understandings and practices concerning mental health.

In my interrogation of *consultation* as a practice, I have identified relations between discourses as a form of power play providing conditions to shape its nature and function. Relations between clinical, familial, and cultural expertise have challenged and tested the boundaries of psychiatric discourse; yet, recognition and assimilation of alternate knowledge have sustained psychiatric discourse as the underlying rule to mental health service provision in Aotearoa New Zealand. In Chapter Seven, I identified how challenges to the dominance of psychiatry and Western thinking became subject to

---

[269] Ministry of Health. (2022). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

[270] Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

adaptation and assimilation. The assimilation of personal *recovery* into policy as a challenge to the oppressive nature of psychiatry 'became' approaches within psychiatry signifying service user and, later, family and whānau 'empowerment'. Its use in challenging contemporary practices as risk-averse and 'outdated' does so within the underlying rules of psychiatric and clinical discourses. Te Whare Tapa Whā in its integration into psychiatric thinking through broadening the constructs of health has been used to signify 'cultural progress', representing services as inclusive for Māori; yet, as a framework in Western services, it continues to operate within psychiatric discourse.

'New approaches' in the field of mental health service provision touted as progressive are rarely so, as noted by Foucault (1971, 1972), through (re)producing and (re)circulating existing knowledge in different ways, sustaining knowledge/power relations. This reasoning was exampled by Cohen (2014) regarding the 'social model of health', that provided context of socio-economic and cultural factors explaining health rates and outcomes but continued to normalise psychiatric discourse as an underlying rule. Poverty, as an example, has been used as a condition for the development of mental illness as opposed to indicating wider problems within institutions affecting people. Changes to *consultation* in future Acts will most likely sustain psychiatric and clinical discourses; of interest will be how alternative discourses operate as forces of power to enable shifts in thinking and practices.

Final Thinking

This thesis has drawn from the works of Foucault and others following in similar steps to present a genealogical analysis of *consultation*. Using a 'history of the present' approach, I have identified dominant and marginalised discourses operating within mental health service provision that provided and continues to provide the conditions for *consultation* between family and whānau and clinicians. A Foucauldian discursive analysis has offered insights into an area of practice not previously researched in-depth from a poststructural stance, making visible the underlying rules shaping policy and practices. What was thinkable and doable concerning *consultation* in the past has shaped current practices and will continue to shape future iterations. My hope from this thesis is that by making visible the contingent nature of thinking considered 'rational' and 'normal' provides opportunities to see things in a different light. I do not propose specific 'findings' (in keeping with Foucauldian discourse analysis methodologies);

rather, make visible some of the complexities, contradictions, and tensions producing the concept and strategy of *consultation.*

As noted within the introduction, analysis from another researcher using the same text and similar methods of analysis would undoubtedly identify other 'findings', refuting the notion of 'results'. This thinking could be considered a limitation from within alternate epistemological positions, and a strength from within a Foucauldian inspired stance. Instead, I propose that my lines of enquiry have made visible certain things that can be taken up and further explored when considering the notion and function of *consultation* in compulsory assessment and treatment, in law, policy, and practices.

The two main arguments explicated from my analysis in this discussion chapter, represent this thinking. They are not and do not contain 'findings' representing an 'answer'; rather, signify a line of inquiry that enabled me to think about *consultation* in such ways. The dominance of *risk* discourses within mental health service provision (prior to and) following *community care* enabled me to think about how *risks* can be situated within family and whānau and, in doing so, what this might imply. This questioning assisted me to consider Section 7A *consultation* as a strategy functioning to manage the *risks* of the *patient* and the family and whānau. In doing so, I was then able to think about the different ways this played out through constructions of 'family' and 'whānau'. In thinking about 'family' as individualistic and whānau as collectivistic constructs, I could then consider Section 7A *consultation* as a tool of colonisation within psychiatric discourse through favouring individualistic European culture and thus marginalising collective cultures. I consider these lines of enquiry significant contextual to current critique of compulsory assessment and treatment practices as *risk-averse* and causing inequitable health outcomes for the Māori population.

Finally, some thinking on the tensions between my roles as a researcher and a clinician facilitating compulsory assessment and treatment practices. I am aware that, as with any area of health, significant distress and potential danger for those experiencing mental illness, their family and whānau, and community members requires a sense of urgency at times. The experience of compulsory assessment and the myriad contexts leading to this practice can, in research, detract from the intricate complexities situated within each event. Possibilities for modifying or shaping *consultation* through consideration of arguments made in this thesis is not intended to diminish or eliminate a sense of urgency to difficult situations. In some events, for the health and safety of people, family and whānau, community members, and clinical staff, an urgent response is required, and sometimes this may need to exclude ‘*consultation*’ with family and whānau in moments of acuity and ‘*risk*’. As a clinician I am also aware of some of the constraints in identifying and working alongside family and whānau in acute situations, contextual to current resources. However, future iterations of *consultation* do not need to play out as currently employed on post-acute situations. As my thesis has demonstrated, *consultation* has taken different forms prior to its emergence as Section 7A, and experienced discursive shifts, such as increased Te Ao Māori (worldview) within Western service provision and the development of Kaupapa Māori (Māori approaches) to health. With calls to repeal and replace the MHA, 1992 arises the possibility to review the constructs and functions shaping *consultation* within compulsory assessment and treatment practices. In order to do things differently, to get better outcomes, collaboration between researchers, monitors, advocates, and those directly involved in practices is crucial.

References

Adame, A. L., & Knudson, R. M. (2007). Beyond the counter-narrative: Exploring alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry, 17*(2), 157-178. https://doi.org/10.1075/ni.17.2.02ada

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology, 17*(1), 105-131. https://doi.org/10.1146/annurev.so.17.080191.000541

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (1st edition ed.). Author.

Andresen, R., Caputi, P., & Oades, L. (2006). Stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry, 40*(11-12), 972-980. https://doi.org/10.1080/17522430902948167

Armstrong, P. (2015). The discourse of Michel Foucault: A sociological encounter. *Critical Perspectives on Accounting, 27*, 29-42. https://doi.org/10.1016/j.cpa.2013.10.009

Atmore, C. (1995). Drawing the line: Issues of boundary and the homosexual law reform Bill campaign in New Zealand (Aotearoa), 1985-86. *Journal of Homosexuality, 30*(1), 23-52. https://doi.org/10.1300/J082v30n01_02

Bacchi, C. (2000). Policy as discourse: What does it mean? Where does it get us? *Discourse: Studies in the Cultural Politics of Education, 21*(1), 45-57. https://doi.org/10.1080/01596300050005493

Baker, G. (2024). Te Aka Whai Ora deserved so much more than its rushed death. *The Spinoff*. Retrieved from https://thespinoff.co.nz/atea/29-02-2024/te-aka-whai-ora-deserved-so-much-more-than-its-rushed-death

Barlow, J. (1845). On man's power over himself to prevent or control insanity *American Journal of Psychiatry, 1*(4), 289-319. http://doi.org/10.1176/ajp.1.4.289

Barthes, R. (2001). The death of the author. *Contributions in Philosophy, 83*, 3-8.

Berlim, M. T., Fleck, M. P. A., & Shorter, E. (2003). Notes on antipsychiatry. *European Archives of Psychiatry and Clinical Neuroscience, 253*(2), 61-67. https://doi.org/10.1007/s00406-003-0407-8

Bevir, M. (1999). Foucault, power, and institutions. *Political Studies, 47*(2), 345-359. https://doi.org/10.1111/1467-9248.00204

Boek, W. E. (1957). Social science applied to the dynamics of community process. *Adult Education, 7*(3), 174-178. https://doi.org/10.1177/074171365700700305

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *The Annals of Family Medicine, 2*(6), 576-582. https://doi.org/10.1370/afm.245

Boulton, A. (2019). Whanau ora: A culturally-informed, social policy innovation. *New Zealand Sociology, 34*(2), 23-48. https://doi.org/10.3316/informit.901114827368735

Bowman, G. (1997). Identifying versus identifying with 'the other': Reflections on the siting of the subject in anthropological discourse. In A Dawson, J. Hockey, & A. James (Eds.), *After writing culture: Epistemology and praxis in contemporary anthropology* (pp. 44-60). Routledge.

Bradbury-Jones, C., Sambrook, S., & Irvine, F. (2008). Power and empowerment in nursing: A fourth theoretical approach. *Journal of Advanced Nursing, 62*(2), 258-266. https://doi.org/10.1111/j.1365-2648.2008.04598.x

Bray, M., & Walsh, P. (1998). Different paths to neo-liberalism? Comparing Australia and New Zealand. *Industrial Relations: A Journal of Economy and Society, 37*(3), 358-387. https://doi.org/10.1111/0019-8676.00092

Breetzke, G. D., Curtis-Ham, S., Gilbert, J., & Tibby, C. (2022). Gang membership and gang crime in New Zealand: A national study identifying spatial risk factors. *Criminal Justice and Behavior, 49*(8), 1154-1172. https://doi.org/10.1177/00938548211034200

Brickell, C. (2022). AIDS, love and the law: From the Human Rights Act to marriage equality in New Zealand. *Journal of Australian Studies, 46*(3), 339-353. https://doi.org/10.1080/14443058.2022.2090996

Brun, C., & Rapp, R. C. (2001). Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social Work, 46*(3), 278-288. https://doi.org/10.1093/sw/46.3.278

Brunton, W. (2003). The origins of deinstitutionalisation in New Zealand. *Health and History, 5*(2), 75-103. https://doi.org/10.2307/40111454

Bryan, J., & Henry, L. (2008). Strengths-based partnerships: A school-family-community partnership approach to empowering students. *Professional School Counseling, 12*(2), 2156759X0801200202. https://doi.org/10.1177/2156759X08012002

Bryson, L. (1992). *Welfare and the state*. Macmillan Press.

Bucknill, J. C., & Tuke, D. H. (1879). *A manual of psychological medicine: Containing the lunacy laws, the nosology, aetiology, statistics, description, diagnosis, pathology, and treatment of insanity: With an appendix of cases*. J. & A. Churchill.

Burkitt, I. (2002). Technologies of the self: Habitus and capacities. *Journal for the Theory of Social Behaviour, 32*(2), 219-237. https://doi.org/10.1111/1468-5914.00184

Butts, H. F. (1979). Frantz Fanon's contribution to psychiatry: The psychology of racism and colonialism. *Journal of the National Medical Association, 71*(10), 1015.

Buus, N. (2001). Tangled ruptures: Discursive changes in Danish psychiatric nursing 1965–75. *Nursing Inquiry, 8*(4), 246-253. https://doi.org/10.1046/j.1440-1800.2001.00114.x

Calvert-Minor, C. (2010). Archeology and humanism: An incongruent Foucault. *Kritike: An Online Journal of Philosophy, 4*(1), 1-17. https://www.kritike.org/journal/issue_7/calvert-minor_june2010.pdf

Cambridge Dictionary. (2023). *Risk*. https://dictionary.cambridge.org/dictionary/english/risk

Came, H. (2013). Doing research in Aotearoa: A Pākehā exemplar of applying Te Ara Tika ethical framework. *Kotuitui: New Zealand Journal of Social Sciences Online, 8*(1-2), 64-73. https://doi.org/10.1080/1177083X.2013.841265

Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI 2575 report: Implications for decolonizing health systems. *Health and Human Rights, 22*(1), 209. https://www.hhrjournal.org/2020/06/the-waitangi-tribunals-wai-2575-report-implications-for-decolonizing-health-systems/

Caplan, J. (1989). Postmodernism, poststructuralism, and deconstruction: Notes for historians. *Central European History, 22*(3-4), 260-278. https://doi.org/ https://doi.org/10.1017/S0008938900020483

Chamberlin, J. (1990). The ex-patients' movement: Where we've been and where we're going. *Journal of Mind and Behavior, 11*(3), 323-336. http://www.brown.uk.com/brownlibrary/CHAMB.htm

Cheyne, C., O'Brien, M., & Belgrave, M. (2008). *Social policy in Aotearoa New Zealand* (4th ed.). Oxford University Press.

Christie, N. (2009). *Access to marriage for same-sex couples in New Zealand: A matter of human rights* [Unpublished doctoral thesis, The University of Waikato]. https://hdl.handle.net/10289/3277

Cohen, B. (2014). Passive-aggressive: Māori resistance and the continuance of colonial psychiatry in Aotearoa New Zealand. *Disability and the Global South, 1*(2), 319-339. http://hdl.handle.net/2292/38386

Cohen, B. M. (2020). A postcolonial critique of mental health: Empire and psychiatric expansionism. In R. Moodley & E. Lee (Eds.), *The Routledge international handbook of race, culture and mental health* (pp. 32-42). Routledge.

Cooper, R., & Burrell, G. (1988). Modernism, postmodernism and organizational analysis: An introduction. *Organization Studies, 9*(1), 91-112. https://doi.org/10.1177/017084068800900112

Cox, S., Hocking, C., Payne, D., & Fadyl, J. (2024). Reflections on the ethics of using Western philosophy to guide research in Aotearoa. *New Zealand Journal of Occupational Therapy, 71*(1).

Crossley, N. (2002). Mental health, resistance and social movements: The collective-confrontational dimension. *Health Education Journal, 61*(2), 138-152. https://doi.org/10.1177/001789690206100205

Crossley, N. (2004). Not being mentally ill: Social movements, system survivors and the oppositional habitus. *Anthropology & Medicine, 11*(2), 161-180. https://doi.org/10.1080/13648470410001678668

Crossley, N. (2006). The field of psychiatric contention in the UK, 1960–2000. *Social Science and Medicine, 62*(3), 552-563. https://doi.org/10.1016/j.socscimed.2005.06.016

Curtis, E., Jones, R., Willing, E., Anderson, A., Paine, S.-J., Herbert, S., Loring, B., Dalgic, G., & Reid, P. (2023). Indigenous adaptation of a model for understanding the determinants of ethnic health inequities. *Discover Social Science and Health, 3*(1), 10. https://doi.org/10.1007/s44155-023-00040-6

Davies, L., & Dax, E. C. (1974). The criminal and social aspects of families with a multiplicity of problems. *Australian & New Zealand Journal of Criminology, 7*(4), 197-213. https://doi.org/10.1177/000486587400700404

Davies, W. (2014). Neoliberalism: A bibliographic review. *Theory, Culture & Society, 31*(7-8), 309-317. https://doi.org/10.1177/0263276414546383

Deacon, R. (2002). An analytics of power relations: Foucault on the history of discipline. *History of the human Sciences, 15*(1), 89-117. https://doi.org/10.1177/0952695102015001074

Deegan, P. E. (1991). *Recovery, rehabilitation and the conspiracy of hope.* Keynote address at the Northeast Regional Training Institute and Conference on Housing Supports. https://www.patdeegan.com/sites/default/files/files/conspiracy_of_hope.pdf

Deegan, P. E. (1993). Recovering our sense of value after being labeled: Mentally ill. *Journal of Psychosocial Nursing and Mental Health Services, 31*(4), 7-9. https://doi.org/10.3928/0279-3695-19930401-06

Department of Health. (1969). *A review of hospital and related services in New Zealand.* New Zealand Department of Health. https://archive.org/details/b32172588

Devereux, C. (2014). Hysteria, feminism, and gender revisited: The case of the second wave. *ESC: English Studies in Canada, 40*(1), 19-45. https://doi.org/10.1353/esc.2014.0004

Dictionary.com. (2023). *Discourse analysis.* Retrieved from https://www.dictionary.com/browse/discourse-analysis

Dixon, L. B., Glynn, S. M., Cohen, A. N., Drapalski, A. L., Medoff, D., Fang, L. J., Potts, W., & Gioia, D. (2014). Outcomes of a brief program, REORDER, to promote consumer recovery and family involvement in care. *Psychiatric Services, 65*(1), 116-120. https://doi.org/10.1176/appi.ps.201300074

Domingue, J. L., Jacob, J. D., Perron, A., Pariseau-Legault, P., & Foth, T. (2023). A critical ethnographic perspective on risk and dangerousness in forensic psychiatry. *Nursing Inquiry, 30*(2), e12521. https://doi.org/10.1111/nin.12521

Dreyfus, H. L., & Rabinow, P. (1982). *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed.). The University of Chicago.

Dupuis-Rossi, R. (2021). The violence of colonization and the importance of decolonizing therapeutic relationship: The role of helper in centring Indigenous wisdom. *International Journal of Indigenous Health, 16*(1). https://doi.org/10.32799/ijih.v16i1.33223

Durie, M. (2004). An indigenous model of health promotion. *Health Promotion Journal of Australia, 15*(3), 181-185. https://doi.org/10.1071/HE04181

Durie, M. (2006). *Whānau, education and Māori potential.* Retrieved from https://www.massey.ac.nz/documents/497/Whanau-education.pdf

Durie, M. H. (1985). A Maori perspective of health. *Social Science and Medicine, 20*(5), 483-486. https://doi.org/10.1016/0277-9536(85)90363-6

Easton, B. (1980). *Social policy and the welfare state in New Zealand*. George Allen & Unwin.

Elers, P. (2014). Māori health: Issues relating to health care services. *Te Kaharoa, 7*(1), 163-172. https://doi.org/10.24135/tekaharoa.v7i1.51

Elliott, M. (2017). *People's mental health report*. https://static1.squarespace.com/static/58f48f2459cc680bc7a237aa/t/58f5d384b8a79b4768cb93a8/1492505610169/PMHR+%28FINAL%29.pdf

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136. https://doi.org/10.1521/pdps.2012.40.3.377

Engstrom, E. J., & Weber, M. M. (2005). The directions of psychiatric research by Emil Kraepelin. *History of Psychiatry, 16*(3), 345-349. https://doi.org/10.1177/0957154X05056763

Esposito, L., & Perez, F. M. (2014). Neoliberalism and the commodification of mental health. *Humanity & Society, 38*(4), 414-442. https://doi.org/10.1177/0160597614544958

Esquirol, E. (1845). *Mental maladies; A treatise on insanity*. Lea and Blanchard.

Fadyl, J. K., Nicholls, D. A., & McPherson, K. M. (2013a). Foucault, the subject and the research interview: A critique of methods. *Nursing Inquiry, 20*(1), 23-29. https://doi.org/10.1111/nin.12011

Fadyl, J. K., Nicholls, D. A., & McPherson, K. M. (2013b). Interrogating discourse: The application of Foucault's methodological discussion to specific inquiry. *Health, 17*(5), 478-494. https://doi.org/10.1177/1363459312464073

Fairclough, N. (2000). Discourse, social theory, and social research: The discourse of welfare reform. *Journal of sociolinguistics, 4*(2), 163-195. https://doi.org/10.1111/1467-9481.00110

Feder, E. K. (2011). Power/knowledge. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 55-70). Acumen.

Fiorillo, A., De Rosa, C., Del Vecchio, V., Jurjanz, L., Schnall, K., Onchev, G., Alexiev, S., Raboch, J., Kalisova, L., & Mastrogianni, A. (2011). How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study. *European Psychiatry, 26*(4), 201-207. https://doi.org/10.1016/j.eurpsy.2010.01.013

Fischhoff, B., Hope, C., & Watson, S. R. (2013). Defining risk. In T. S. Glickman & M. Gough (Eds.), *Readings in risk* (pp. 30-42). RFF Press.

Førde, R., Norvoll, R., Hem, M. H., & Pedersen, R. (2016). Next of kin's experiences of involvement during involuntary hospitalisation and coercion. *BMC Medical Ethics, 17*(1), 76. https://doi.org/10.1186/s12910-016-0159-4

Foucault, M. (1971). Orders of discourse. *Social science information, 10*(2), 7-30. https://doi.org/10.1177/053901847101000201

Foucault, M. (1972). *The archaeology of knowledge* (A. M. S. Smith, Trans.). Routledge

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Penguin.

Foucault, M. (1978). *The history of sexuality: Volume I*. Penguin Books

Foucault, M. (1984a). *The history of sexuality. Volume 2: The use of pleasure.* (R. Hurley, Trans.). Penguin Books.

Foucault, M. (1984b). Nietzsche, genealogy, history. In P. Rabinow (Ed.), *The Foucault reader* (pp. 76-100). Penguin Books.

Foucault, M. (1984c). Right of death and power over life. In P. Rabinow (Ed.), *The Foucault reader* (pp. 258-272). Penguin Books.

Foucault, M. (1984d). What is an author? In P. Rabinow (Ed.), *The Foucault reader* (pp. 101-120). Penguin Classics.

Foucault, M. (1984e). What is enlightenment? In P. Rabinow (Ed.), *The Foucault reader* (pp. 32-50). Penguin Classics.

Foucault, M. (1989). *Madness and civilization: A history of insanity in the age of reason*. Routledge.

Foucault, M. (1994a). About the concept of the 'dangerous individual'. In J. D. Faubion (Ed.), *Michel Foucault Power: Essential works of Foucault 1954-1984.* (Vol. 3, pp. 176-200). Penguin Books.

Foucault, M. (1994b). Governmentaility. In J. D. Faubion (Ed.), *Michel Foucault: Power, essential works of Foucault 1954-1984* (Vol. 3, pp. 201-222). Penguin Books.

Foucault, M. (1994c). Interview with Michel Foucault. In J. D. Faubion (Ed.), *Michel Foucault Power: Essential works of Foucault 1954-1984* (Vol. 3, pp. 239-297). Penguin Books.

Foucault, M. (1994d). Lives of infamous men. In J. D. Faubion (Ed.), *Michel Foucault Power: Essential works of Foucault 1954-1984* (Vol. 3, pp. 157-175). Penguin Books.

Foucault, M. (1994e). Polemics, politics, and problematizations. In P. Rabinow (Ed.), *Michel Foucault: Ethics, essential works of Foucault 1954-1984* (Vol. 1, pp. 111-120). Penguin Books.

Foucault, M. (1994f). Sex, power and politics of identity. In P. Rabinow (Ed.), *Michel Foucault: Ethics, essential works of Foucault 1954-1984* (Vol. 1, pp. 163-174). Penguin Books.

Foucault, M. (1994g). So is it important to think? In J. D. Faubion (Ed.), *Michel Foucault: Power, essential works of Foucault 1954-1984* (Vol. 3, pp. 454-458). Penguin Books.

Foucault, M. (1994h). The subject and power. In J. D. Faubion (Ed.), *Michel Foucault: Power, essential works of Foucault 1954-1984* (Vol. 3, pp. 326-348). Penguin Books.

Foucault, M. (1994i). Technologies of the self. In P. Rabinow (Ed.), *Michel Foucault: Ethics, essential works of Foucault 1954-1984* (Vol. 1, pp. 223-252). Penguin Books.

Foucault, M. (1994j). Truth and juridical forms In J. D. Faubion (Ed.), *Michel Foucault: Power, essential works of Foucault 1954-1984* (Vol. 3, pp. 1-89). Penguin Books.

Foucault, M. (1994k). Truth and power. In J. D. Faubion (Ed.), *Michel Foucault: Power, essential works of Foucault 1954-1984* (Vol. 3, pp. 111-133). Penguin Books.

Foucault, M. (2003). 5 March 1975 (G. Burchell, Trans.). In V. Marchetti & A. Salomoni (Eds.), *Abnormal: Lectures at the College de France 1974-1975* (pp. 231-262). Verso.

Foucault, M. (2008a). 7 March 1979 (G. Burchell, Trans.). In M. Senellart (Ed.), *The birth of biopolitics: Lectures at the Collège de France 1978-1979* (pp. 185-213). Picador.

Foucault, M. (2008b). 14 February 1979 (G. Burchell, Trans.). In M. Senellart (Ed.), *The birth of biopolitics: Lectures at the Collège de France 1978-1979* (pp. vii-viii). Picador.

Foucault, M. (2011). *Madness: The invention of an idea*. Harper Perennial Modern Thought.

Frederiksen, K., Lomborg, K., & Beedholm, K. (2015). Foucault's notion of problematization: A methodological discussion of the application of Foucault's later work to nursing research. *Nursing Inquiry, 22*(3), 202-209. https://doi.org/10.1111/nin.12094

Friedman, C. J., & Friedman, A. S. (1970). Characteristics of schizogenic families during a joint story-telling task. *Family Process, 9*(3), 333-353. https://doi.org/10.1111/j.1545-5300.1970.00333.x

Garland, D. (2014). What is a "history of the present"? On Foucault's genealogies and their critical preconditions. *Punishment & Society, 16*(4), 365-384. https://doi.org/10.1177/1462474514541711

Gershon, I. (2008). Being explicit about culture: Māori, neoliberalism, and the New Zealand parliament. *American Anthropologist, 110*(4), 422-431. https://doi.org/10.1111/j.1548-1433.2008.00075.x

Gibbs, A., Dawson, J., Forsyth, H., Mullen, R., & Tanga, T. O. T. (2004). Maori experience of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry, 38*(10), 830-835. https://doi.org/10.1080/j.1440-1614.2004.01468.x

Gibbs, A., Dawson, J., & Mullen, R. (2006). Community treatment orders for people with serious mental illness: A New Zealand study. *British Journal of Social Work, 36*(7), 1085-1100. https://doi.org/10.1093/bjsw/bch392

Gilbert, J. (2019). New Zealand: Patched gangs, police and political corruption. In F. Allum & S. Gilmour (Eds.), *Handbook of organised crime and politics* (pp. 363-373). Edward Elgar Publishing. https://doi.org/10.4337/9781786434579.00036

Graham, L. J. (2005a). *Discourse analysis and the critical use of Foucault.* Australian Association for Research in Education, Sydney, Australia. https://eprints.qut.edu.au/2689/1/2689.pdf

Graham, L. J. (2005b). *Schooling and 'disorderly objects': Doing discourse analysis using Foucault.* Australian Association for Research in Education Annual Conference 2005, Sydney, Australia. https://eprints.qut.edu.au/3830/1/3830a.pdf

Graham, L. J. (2011). The product of text and ‘other’statements: Discourse analysis and the critical use of Foucault. *Educational Philosophy and Theory, 43*(6), 663-674. https://doi.org/10.1111/j.1469-5812.2010.00698.x

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health, 44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971

Gray, M. (2003). Urban surveillance and panopticism: Will we recognize the facial recognition society? *Surveillance & Society, 1*(3), 314-330. https://doi.org/10.24908/ss.v1i3.3343

Greaves, L. M., Le Grice, J., Schwencke, A., Crengle, S., Lewycka, S., Hamley, L., & Clark, T. C. (2021). Measuring whanaungatanga and identity for well-being in rangatahi Māori. *MAI Journal, 10*(2), 93-105. https://doi.org/10.20507/MAIJournal.2021.10.2.3

Greif, A. (2006). Family structure, institutions, and growth: The origins and implications of western corporations. *American Economic Review, 96*(2), 308-312. https://doi.org/10.1257/000282806777212602

Gronfein, W. (1985). Psychotropic drugs and the origins of deinstitutionalization. *Social Problems, 32*(5), 437-454. https://doi.org/10.2307/800774

Hackell, M. (2016). Managing anxiety: Neoliberal modes of citizen subjectivity, fantasy and child abuse in New Zealand. *Citizenship Studies, 20*(6-7), 867-882. https://doi.org/10.1080/13621025.2016.1204270

Haitana, T., Pitama, S., Cormack, D., Clark, M. T. R., & Lacey, C. (2022a). Culturally competent, safe and equitable clinical care for Māori with bipolar disorder in New Zealand: The expert critique of Māori patients and Whānau. *Australian and New Zealand Journal of Psychiatry, 56*(6), 648-656. https://doi.org/10.1177/00048674211031490

Haitana, T., Pitama, S., Cormack, D., Clark, M. T. R., & Lacey, C. (2022b). “If we can just dream…” Māori talk about healthcare for bipolar disorder in New Zealand: A qualitative study privileging Indigenous voices on organisational transformation for health equity. *The International Journal of Health Planning and Management, 37*(5), 2613-2634. https://doi.org/10.1002/hpm.3486

Haitana, T., Pitama, S., Cormack, D., Rangimarie Clark, M. T., & Lacey, C. (2023). ‘It absolutely needs to move out of that structure’: Māori with bipolar disorder identify structural barriers and propose solutions to reform the New Zealand mental health system. *Ethnicity and Health, 28*(2), 234-256. https://doi.org/10.1080/13557858.2022.2027884

Hallam, L. (2007). How involuntary commitment impacts on the burden of care of the family. *International Journal of Mental Health Nursing, 16*(4), 247-256. https://doi.org/10.1111/j.1447-0349.2007.00474.x

Hardy, N. (2011). Foucault, genealogy, emergence: Re-examining the extra-discursive. *Journal for the Theory of Social Behaviour, 41*(1), 68-91. https://doi.org/10.1111/j.1468-5914.2010.00446.x

Hassan, I. (1985). The culture of postmodernism. *Theory, Culture & Society, 2*(3), 119-131. https://doi.org/10.1177/0263276485002003010

Health and Disability Commissioner. (2020). *Aotearoa New Zealand's mental health services and addiction services: The monitoring and advocacy report of the Mental Health Commissioner*. Author. https://www.hdc.org.nz/our-work/mental-health-addictions/monitoring-and-advocacy-report-of-the-mental-health-commissioner-2020/

Heaton, J. (1999). The gaze and visibility of the carer: A Foucauldian analysis of the discourse of informal care. *Sociology of Health and Illness, 21*(6), 759-777. https://doi.org/10.1111/1467-9566.00182

Hei Ahuru Mowai Maori Cancer Leadership Aotearoa. (2024). Te Aka Whai Ora disestablishment 'damaging' For Māori health equity. *Scoop* https://www.scoop.co.nz/stories/PO2403/S00004/te-aka-whai-ora-disestablishment-damaging-for-maori-health-equity.htm

Heriot-Maitland, C. (2011). Exploring the compatibility of biomedical and psychological approaches to treating psychosis. *Psychosis, 3*(2), 133-140. https://doi.org/10.1080/17522439.2010.518320

Hikuroa, D. (2017). Mātauranga Māori—the ūkaipō of knowledge in New Zealand. *Journal of the Royal Society of New Zealand, 47*(1), 5-10. https://doi.org/10.1080/03036758.2016.1252407

Hilder, J., Charles-Edwards, E., Sigler, T., & Metcalf, B. (2018). Housemates, inmates and living mates: Communal living in Australia. *Australian Planner, 55*(1), 1-16. https://doi.org/10.1080/07293682.2018.1494612

Hirshbein, L. (2010). Sex and gender in psychiatry: A view from history. *Journal of Medical Humanities, 31*, 155-170. https://doi.org/10.1007/s10912-010-9105-5

Hoffman, M. (2011). Disciplinary power. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 27-39). Acumen.

Hokowhitu, B. (2014). If you are not healthy, then what are you?: Healthism, colonial disease and body-logic. In R. Tinning & K. Fitzpatrick (Eds.), *Health education: critical perspectives* (pp. 31-47). Routledge.

Hokowhitu, B., Oetzel, J., Jackson, A.-M., Simpson, M., Ruru, S., Cameron, M., Zhang, Y., Erueti, B., Rewi, P., & Nock, S. (2022). Mana motuhake, Indigenous biopolitics and health. *AlterNative: An International Journal of Indigenous Peoples, 18*(1), 104-113. https://doi.org/10.1177/1177180122108844

Holmes, D., & Gagnon, M. (2018). Power, discourse, and resistance: Poststructuralist influences in nursing. *Nursing Philosophy, 19*(1), e12200. https://doi.org/10.1111/nup.12200

Holton, G. A. (2004). Defining risk. *Financial Analysts Journal, 60*(6), 19-25. https://doi.org/10.2469/faj.v60.n6.2669

Hook, D. (2001). Discourse, knowledge, materiality, history, Foucault and discourse analysis. *Theory & Psychology, 11*(4), 521-547. https://doi.org/10.1177/0959354301114006

Hook, G. R. (2009). Warrior genes" and the disease of being Māori. *MAI review, 2*, 1-11. https://www.journal.mai.ac.nz/system/files/maireview/222-1507-1-PB.pdf

Horkheimer, M., & Adorno, T. W. (2002). *Dialectic of enlightenment: Philosophical fragments*. Stanford University Press.

Houkamau, C., Tipene-Leach, D., & Clarke, K. (2016). The high price of being labelled "high risk": Social context as a health determinant for sudden unexpected infant death in Māori communities. *New Zealand College of Midwives Journal, 52*, 56-61.

Houkamau, C. A., Stronge, S., & Sibley, C. G. (2017). The prevalence and impact of racism toward indigenous Māori in New Zealand. *International Perspectives in Psychology, 6*(2), 61-80. https://doi.org/10.1037/ipp0000070

Humpage, L., & Craig, D. (2008). From welfare to welfare-to-work. In N. Lunt, M. O'Brien, & R. Stephens (Eds.), *New Zealand, new welfare* (pp. 41-48). Cengage Learning.

Jablensky, A. (2007). Living in a Kraepelinian world: Kraepelin's impact on modern psychiatry. *History of Psychiatry, 18*(3), 381-388. https://doi.org/10.1177/0957154X07079690

Jager, F., & Perron, A. (2023). How identity is produced and experienced in the context of mandated community-based mental health care: An application of the theories of Grosz and Foucault. *Nursing Inquiry, 30*(3), e12552. https://doi.org/10.1111/nin.12552

Jansen, I. (2008). Discourse analysis and Foucault's "Archaeology of knowledge". *International Journal of Caring Sciences, 1*(3), 107-111. https://internationaljournalofcaringsciences.org/docs/Vol1_Issue3_01_Jansen.pdf

Jeffery, H. (2005). Culture clash: A discussion of the provision of mental health services for Maori consumers in New Zealand. *New Zealand Journal of Occupational Therapy, 52*(2), 15-21. https://doi.org/10.3316/informit.080719013104543

Johnston, M. S., Sanscartier, M. D., & Steckle, R. (2023). Patient resistance to psychiatric discourse and power. *Disability Studies Quarterly, 42*(3-4). https://doi.org/10.18061/dsq.v42i3-4.7808

Jones, L. (2018). Pastoral power and the promotion of self-care. *Sociology of Health and Illness, 40*(6), 988-1004. https://doi.org/10.1111/1467-9566.12736

Joseph, A. E., & Kearns, R. A. (1996). Deinstitutionalization meets restructuring: The closure of a psychiatric hospital in New Zealand. *Health & Place, 2*(3), 179-189. https://doi.org/10.1016/1353-8292(96)00011-1

Joseph, A. E., Kearns, R. A., & Moon, G. (2009). Recycling former psychiatric hospitals in New Zealand: Echoes of deinstitutionalisation and restructuring. *Health & Place, 15*(1), 79-87. https://doi.org/10.1016/j.healthplace.2008.02.005

Keller, R. (2001). Madness and colonization: Psychiatry in the British and French empires, 1800-1962. *Journal of Social History, 35*(2), 295-326. https://doi.org/10.1353/jsh.2001.0126

Kidd, J., Gibbons, V., Lawrenson, R., & Johnstone, W. (2010). A whanau ora approach to health care for Maori. *Journal of Primary Health Care, 2*(2), 163-164.

Kiyimba, N., & Anderson, R. (2022). Reflecting on cultural meanings of spirituality/wairuatanga in post-traumatic growth using the Māori wellbeing model of Te Whare Tapa Whā. *Mental Health, Religion & Culture, 25*(3), 345-361. https://doi.org/10.1080/13674676.2022.2028750

Komene, E., Pene, B., Gerard, D., Parr, J., Aspinall, C., & Wilson, D. (2024). Whakawhanaungatanga—Building trust and connections: A qualitative study indigenous Māori patients and whānau (extended family network) hospital experiences. *Journal of Advanced Nursing, 80*(4), 1545-1558. https://doi.org/10.1111/jan.15912

Kopua, D. M. (2019). Factors that facilitate and constrain the utilization of a Kaupapa Māori therapeutic approach with Mahi-a-Atua. *Australasian Psychiatry, 27*(4), 341-344. https://doi.org/10.1177/10398562188101

Krug, G., & Hepworth, J. (1997). Poststructuralism, qualitative methodology and public health: Research methods as a legitimation strategy for knowledge. *Critical Public Health, 7*(1-2), 50-60. https://doi.org/10.1080/09581599708409078

Lacey, C., Lawrence, M., Paterson, C., & Every-Palmer, S. (2022). Voices forgotten or a future of inclusion and equity: An Aotearoa New Zealand perspective on better publication of Indigenous mental health research. *56*(8), 895-898. https://doi.org/10.1177/00048674221113

Larner, W. (1997). “A means to an end”: Neoliberalism and state processes in New Zealand. *Studies in Political Economy, 52*(1), 7-38. https://doi.org/10.1080/19187033.1997.11675320

Larner, W. (2000). Neo-liberalism: Policy, ideology, governmentality. *Studies in Political Economy, 63*(1), 5-25. https://doi.org/10.1080/19187033.2000.11675231

Lavin, M. F., & Barnes, M. W. (2020). Normalizing deviants: Notes on the de-stigma trend. *Deviant Behavior, 41*(7), 828-840. https://doi.org/10.1080/01639625.2020.1763108

Le Grice, J., Braun, V., & Wetherell, M. (2017). "What I reckon is, is that like the love you give to your kids they'll give to someone else and so on and so on": Whanaungatanga and mātauranga Māori in practice. *New Zealand Journal of Psychology, 46*(3), 88-97. https://www.psychology.org.nz/journal-archive/Whanaungatanga-and-m%C4%81tauranga-M%C4%81ori-in-practice-private.pdf

Lemkau, P. V. (1958). The mental health board and its role in the community. *American Journal of Orthopsychiatry, 28*(2), 343-351. https://doi.org/10.1111/j.1939-0025.1958.tb03752.x

Lewis, C., Norris, A. N., Heta-Cooper, W., & Tauri, J. (2020). Stigmatising gang narratives, housing, and the social policing of Māori women. In L. George, A. N. Norris, A., Deckert, & J. Tauri (Eds.), *Neo-colonial injustice and the mass imprisonment of Indigenous women* (pp. 13-33). Palgrave Macmillan. https://doi.org/10.1007/978-3-030-44567-6_2

Lilja, M., & Vinthagen, S. (2014). Sovereign power, disciplinary power and biopower: Resisting what power with what resistance? *Journal of Political Power, 7*(1), 107-126. https://doi.org/10.1080/2158379X.2014.889403

Lindsay, N., Haami, D., Tassell-Matamua, N., Pomare, P., Valentine, H., Pahina, J., Ware, F., & Pidduck, P. (2022). The spiritual experiences of contemporary Māori in Aotearoa New Zealand: A qualitative analysis. *Journal of Spirituality in Mental Health, 24*(1), 74-94. https://doi.org/10.1080/19349637.2020.1825152

Lupton, D. (1997). Consumerism, reflexivity and the medical encounter. *Social Science and Medicine, 45*(3), 373-381. https://doi.org/10.1016/S0277-9536(96)00353-X

Lynch, R. A. (2011). Foucault's theory of power. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 13-26). Acumen.

MacDonald, L. (2022). Whose story counts? Staking a claim for diverse bicultural narratives in New Zealand secondary schools. *Race Ethnicity and Education, 25*(1), 55-72. https://doi.org/10.1080/13613324.2020.1798387

Magill, R., Jenkin, G., & Collings, S. (2022). 'Really there because they care': The importance of service users' interpretations of staff motivations at a crisis intervention service in New Zealand. *Health & Social Care in the Community, 30*(5), e1756-e1764. https://doi.org/10.1111/hsc.13603

Manokha, I. (2018). Surveillance, panopticism, and self-discipline in the digital age. *Surveillance & Society, 16*(2), 219-237. https://doi.org/10.24908/ss.v1i3.3343

Manuel, J., Pitama, S., Clark, M., Crowe, M., Crengle, S., Cunningham, R., Gibb, S., Petrović-van der Deen, F. S., Porter, R. J., & Lacey, C. (2023). Racism, early psychosis, and institutional contact: A qualitative study of Indigenous experiences. *International Journal of Social Psychiatry, 69*(8), 2121-2127. https://doi.org/10.1177/00207640231195297

Maree Kopua, D., Kopua, M. A., & Bracken, P. J. (2020). Mahi a Atua: A Māori approach to mental health. *Transcultural psychiatry, 57*(2), 375-383. https://doi.org/10.1177/136346151985160

Mark, G. T., & Lyons, A. C. (2010). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science and Medicine, 70*(11), 1756-1764. https://doi.org/10.1016/j.socscimed.2010.02.001

Martin, G. P., & Waring, J. (2018). Realising governmentality: Pastoral power, governmental discourse and the (re) constitution of subjectivities. *The Sociological Review, 66*(6), 1292-1308. https://doi.org/10.1177/0038026118755616

Mason, K., Johnston, J., & Crowe, J. (1996). *Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services*. Repport of the Ministerial Inquiry to the Minister of Health, Hon. Jenny Shipley.

Mason, K. H. (1988). *Report of the committee of inquiry into procedures used in certain psychaitric hopsitals in relation to admission, discharge or release on leave of certian classes of patients*. https://fyi.org.nz/request/698/response/3470/attach/4/Mason%20Report%20200dpi.pdf

Matthewson, P. (2002). Risk assessment and management in mental health. *Social Work Review, 14*(4), 36-43.

Mayes, C. (2009). Pastoral power and the confessing subject in patient-centred communication. *Journal of Bioethical Inquiry, 6*(4), 483-493. https://doi.org/10.1007/s11673-009-9195-9

McClure, M. (1998). *A civilised community: A history of social security in New Zealand 1898-1998*. Auckland University Press.

McHenry, S. E. (2022). “Gay is good”: History of homosexuality in the DSM and modern psychiatry. *American Journal of Psychiatry Residents' Journal, 18*(1). https://doi.org/10.1176/appi.ajp-rj.2022.180103

Mckenzie, S., & Carter, K. (2010). Measuring whānau: A review of longitudinal studies in New Zealand. *MAI review, 3*(3), 1-11. https://www.journal.mai.ac.nz/maireview/article/845

McLachlan, A. D., Wirihana, R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand Journal of Psychology (Online), 46*(3), 46-54. https://www.psychology.org.nz/journal-archive/Whai-Tikanga-M%C4%81ori-centred-values-in-practice-private.pdf

McLennan, G., Ryan, A., & Spoonley, P. (2004). *Exploring society: Sociology for New Zealand students*. Pearson. https://doi.org/10.1080/01639625.2012.749759

Mead, H. M. (2022). Understanding mātauranga Māori. *E-Tangata*. https://e-tangata.co.nz/comment-and-analysis/understanding-matauranga-maori/?fbclid=IwAR0lHzHEOVNshpp-sBPedjzexYS7inh0oScOavyq0REZ8o8EE5Xsd441-CU

Mease, J. J. (2017). Postmodern/poststructural approaches. *The International Encyclopedia of Organizational Communication*, 1-21. https://doi.org/10.1002/9781118955567.wbieoc167

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Author.

Mental Health Commission. (2007). *Te Haererenga mo te whakaoranga: The journey of recovery for the New Zealand mental health sector 1996-2006*. Author.

Metge, J. (1995). *New growth from old: The whānau in the modern world*. Victoria University Press.

Miller, P., & Rose, N. (1995). Production, identity, and democracy. *Theory and Society, 24*(3), 427-467.

Minister of Health. (2005). *Te tähuhu: Improving mental health 2005–2015,The second New Zealand mental health and addiction plan*. Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/tetahuhu-improvingmentalhealth.pdf

Minister of Health. (2006). *Te kökiri: The mental health and addiction action plan 2006–2015*. Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/te-kokiri-mental-health-addicition-action-plan-2006-2015.pdf

Minister of Health. (2023a). *New Zealand health strategy*. Ministry of Health.

Minister of Health. (2023b). *Pae Tū: Hauora Māori Strategy*. Ministry of Health.

Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services*. http://www.networknorth.org.nz/file/Resources/1994-moh-looking-forward.pdf

Ministry of Health. (1997). *Moving forward: The national mental health plan for more and better services*. Author.

Ministry of Health. (2000). *Family involvement: Guidance notes*. Author.

Ministry of Health. (2002a). *Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa*. Author.

Ministry of Health. (2002b). *'He korowai oranga: Maori health strategy'*. Author.

Ministry of Health. (2006). *Review of the Application of Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author. https://www.health.govt.nz/system/files/documents/publications/review-application-of-section-7a.pdf

Ministry of Health. (2012a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author. https://www.health.govt.nz/system/files/documents/publications/guide-to-mental-health-act.pdf

Ministry of Health. (2012b). *Rising to the challenge: The mental health and addiction service development plan 2012-2017*. Author. http://www.health.govt.nz/system/files/documents/publications/rising-to-the-challenge-mental-health-addiction-service-development-plan-v2.pdf

Ministry of Health. (2012c). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Author. http://www.health.govt.nz/system/files/documents/publications/rising-to-the-challenge-mental-health-addiction-service-development-plan-v2.pdf

Ministry of Health. (2014). *The guide to he korowai oranga: Māori health strategy 2014*. Author. https://www.health.govt.nz/publication/guide-he-korowai-oranga-maori-health-strategy

Ministry of Health. (2018). *Submissions summary report: Government inquiry into mental health and addiction*. Author. https://mentalhealth.inquiry.govt.nz/whats-new/resources/submissions-summary-report/

Ministry of Health. (2020). *Covid 19. Kia kaha, kia māia, kia ora Aotearoa: Psychosocial and mental wellbeing recovery plan*. Author.

Ministry of Health. (2021). *Kia manawanui Aotearoa: Long-term pathway to mental wellbeing*. Author..

Ministry of Health. (2022a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Author.

Ministry of Health. (2022b). *He arotake ngā tūraru. Reviewing risk: A discussion paper*. Author.

Ministry of Health. (2023). *Office of the Director of mental health and addiction services: Regulatory report 1 July 2021 to 30 June 2022*. Author. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-regulatory-report-1-july-2021-30-june-2022

Ministy of Health. (2021). *Transforming our mental health law: A public discussion document*. Author. https://www.health.govt.nz/publication/transforming-our-mental-health-law-public-discussion-document#:~:text=This%20includes%20releasing%20new%20guidelines,people's%20rights%20and%20improve%20safety.

Moeke-Pickering, T. M. (1996). *Maori identity within whanau: A review of literature* [Working Paper]. https://hdl.handle.net/10289/464

Moewaka Barnes, H., & McCreanor, T. (2019). Colonisation, hauora and whenua in Aotearoa. *Journal of the Royal Society of New Zealand, 49*(sup1), 19-33. https://doi.org/10.1080/03036758.2019.1668439

Moncrieff, J. (2007). Co-opting psychiatry: The alliance between academic psychiatry and the pharmaceutical industry. *Epidemiologia e Psichiatria Sociale, 16*(03), 192-196. https://doi.org/10.1017/S1121189X00002268

Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health, 8*(4), 370-382. https://doi.org/10.1057/sth.2009.11

Muir, R., O'Brien, A., Butler, H., & Diamond, D. (2023). Are mental health nurses meeting the requirements of second health professionals in presenting opinions to the court? *Journal of Psychiatric and Mental Health Nursing, 30*(4), 813-821. https://doi.org/10.1111/jpm.12912

Mullen, R., Gibbs, A., & Dawson, J. (2006). Family perspective on community treatment orders: A New Zealand study. *International Journal of Social Psychiatry, 52*(5), 469-478. https://doi.org/10.1177/0020764006066836

Mutu, M. (2018). Behind the smoke and mirrors of the Treaty of Waitangi claims settlement process in New Zealand: No prospect for justice and reconciliation for Māori without constitutional transformation. *Journal of Global Ethics, 14*(2), 208-221. https://doi.org/10.1080/17449626.2018.1507003

Neill, J. (1990). Whatever became of the schizophrenogenic mother? *American Journal of Psychotherapy, 44*(4), 499-505. https://doi.org/10.1176/appi.psychotherapy.1990.44.4.499

Newham, R. (2022). *Mental health awareness week: What can your church do*. Evangelical Alliance Retrieved May 5, 2023, from https://www.eauk.org/news-and-views/what-could-a-mental-health-friendly-church-look-like

Ngawhare, R. M. (2019). *Whakapapa ora: An exploration of Māori identity through whakapapa* [Unpublished master's thesis, University of Waikato]. http://api.digitalnz.org/records/49826536/source

Noiseux, S., Tribble St-Cyr, D., Corin, E., St-Hilaire, P.-L., Morissette, R., Leclerc, C., Fleury, D., Vigneault, L., & Gagnier, F. (2010). The process of recovery of people with mental illness: The perspectives of patients, family members and care providers: Part 1. *BMC Health Services Research, 10*, 1-14. https://doi.org/10.1186/1472-6963-10-161

Norris, C. (1994). What is enlightenment? Kant according to Foucault. In G. Gutting (Ed.), *The Cambridge companion to Foucault* (pp. 159-196). Cambridge University.

Norvoll, R., Hem, M. H., & Lindemann, H. (2018). Family members' existential and moral dilemmas with coercion in mental healthcare. *Qualitative Health Research, 28*(6), 900-915. https://doi.org/10.1177/1049732317750120

Nuffield, E. (1954). The schizogenic mother. *Medical Journal of Australia, 2*(8), 283-286. https://doi.org/10.5694/j.1326-5377.1954.tb66495.x

O'Connor, T. (2021). Whānau must be centre of 'everything'. *Kai Tiaki: Nursing New Zealand, 27*(2), 30-30.

O'Dea, T., & Tucker, S. (2005). *The cost of suicide*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/thecostofsuicidetosociety.pdf

O'Farrell, C. (2005). *Michel Foucault*. Sage.

O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers.* https://www.moh.govt.nz/notebook/nbbooks.nsf/7086510ecd1c88e1cc2573b70071599b/067033516c56b6b3cc256c4800090c9c?OpenDocument

O'Hagan, M. (2014). *Madness made me. A memoir.* Open Box.

Oksala, J. (2011). Freedom and bodies. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 85-98). Acumen.

Olssen, M. (2004). Foucault and Marxism: Rewriting the theory of historical materialism. *Policy Futures in Education, 2*(3-4), 454-482. https://doi.org/10.2304/pfie.2004.2.3.3

Paterson, L. (2011). Government, church and Māori responses to mākutu (Sorcery) in New Zealand in the nineteenth and early twentieth centuries. *Cultural and Social History, 8*(2), 175-194. https://doi.org/10.2752/147800411X12949180694308

Paterson, R., Durie, M., Disley, B., D., R., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction*. Ministry of Health https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

Pene, B. J., Gott, M., Clark, T. C., & Slark, J. (2023). Conceptualising relational care from an Indigenous Māori perspective: A scoping review. *Journal of Clinical Nursing, 32*(19-20), 6879-6893. https://doi.org/10.1111/jocn.16794

Pinel, P. (1806). *A treatise on insanity: In which are contained the principles of a new and more practical nosology of maniacal disorders than has yet been offered to the public* (Vol. 1806). W. Todd. https://wellcomecollection.org/works/ydkdmffr

Pitama, S., Roberton, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Joural of Psychology, 36*(3), 118-125. https://www.psychology.org.nz/journal-archive/Pitamaetal_NZJP36-3_pg118.pdf

Pleasants, R. K. (2011). Men learning feminism: Protecting privileges through discourses of resistance. *Men and Masculinities, 14*(2), 230-250. https://doi.org/10.1177/1097184X1140704

Posner, R. (2011). Post-modernism, post-structuralism, post-semiotics? Sign theory at the fin de siècle. *Semiotica, 1*(4), 9-30. https://doi.org/10.1515/semi.2011.002

Reddington, G. (2017). The case for positive risk-taking to promote recovery. *Mental Health Practice, 20*(7). https://doi.org/10.7748/mhp.2017.e1183

Reupert, A., Maybery, D., Cox, M., & Scott Stokes, E. (2015). Place of family in recovery models for those with a mental illness. *International Journal of Mental Health Nursing, 24*(6), 495-506. https://doi.org/10.1111/inm.12146

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society, 13*(2), 147-164. https://doi.org/10.1080/13698575.2011.556185

Rodgers, D. (2018). The uses and abuses of "neoliberalism". *Dissent, 65*(1), 78-87. https://doi.org/10.1353/dss.2018.0010

Rolleston, A., Miskelly, P., McDonald, M., Wiles, J., Poppe, K., & Doughty, R. (2022). Cultural context in New Zealand: Incorporating kaupapa Māori values in clinical research and practice. *Health Promotion International, 37*(3), daac065. https://doi.org/10.1093/heapro/daac065

Rolleston, T. A. (2024, May 15). Māori health providers seek High Court action against Crown over Te Aka Whai Ora. *Stuff*. https://www.stuff.co.nz/nz-news/350278628/maori-health-providers-seek-high-court-action-against-crown-over-te-aka-whai-ora

Rose, N. (1993). Government, authority and expertise in advanced liberalism. *Economy and Society, 22*(3), 283-299.

Rose, N. (1999). *Powers of freedom* Cambridge University Press.

Rose, N. (2010). ‘Screen and intervene’: Governing risky brains. *History of the Human Sciences, 23*(1), 79-105. https://doi.org/10.1177/0952695109352415

Rothausen, T. J. (1999). ‘Family’in organizational research: A review and comparison of definitions and measures. *Journal of Organizational Behavior, 20*(6), 817-836. https://doi.org/10.1002/(SICI)1099-1379(199911)20:6<817::AID-JOB953>3.0.CO;2-E

Royal, T. A. C. (2012). Politics and knowledge: Kaupapa Māori and mātauranga Māori. *New Zealand Journal of Educational Studies, 47*(2), 30-37. https://doi.org/10.3316/informit.446746674901479

Rust, J. R. (2021). Political theology, pastoral power, and resistance. *Political Theology, 22*(1), 89-94. https://doi.org/10.1080/1462317X.2020.1866813

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*(3), 316-331. https://doi.org/10.1111/j.1939-0025.1987.tb03541.x

Sadler, E., Hawkins, R., Clarke, D. J., Godfrey, M., Dickerson, J., & McKevitt, C. (2018). Disciplinary power and the process of training informal carers on stroke units. *Sociology of Health and Illness, 40*(1), 100-114. https://doi.org/10.1111/1467-9566.12625

Schiffrin, D. (1997). Theory and method in discourse analysis: What context for what unit? *Language & Communication, 17*(2), 75-92. https://doi.org/10.1016/S0271-5309(97)00002-5

Schmidt, J. (2006). What enlightenment was, what it still might be, and why Kant may have been right after all. *American Behavioral Scientist, 49*(5), 647-663. https://doi.org/10.1177/0002764205282215

Scott, C. E. (2009). Foucault, genealogy, ethics. *Journal of Medicine and Philosophy, 34*(4), 350-367. https://doi.org/10.1093/jmp/jhp029

Severinsen, C., & Reweti, A. (2021). Waiora: Connecting people, well-being, and environment through waka ama in aotearoa New Zealand. *Health Promotion Practice, 22*(4), 524-530. https://doi.org/10.1177/15248399209781

Sibley, C. G., Robertson, A., & Kirkwood, S. (2005). Pakeha attitudes toward the symbolic and resource-specific aspects of bicultural policy in New Zealand: The legitimizing role of collective guilt for historical injustices. *New Zealand Journal of Psychology, 34*(3), 171. https://www.psychology.org.nz/journal-archive/NZJP-Vol343-2005-5-Sibley.pdf

Skipworth, J. (2013). Should involuntary patients with capacity have the right to refuse treatment. In J. Dawson & K. Gledhil (Eds.), *New Zealand's mental health Act in practice* (pp. 213-228). Victoria Univerity Press.

Slade, M. (2010). Measuring recovery in mental health services. *Israel Journal of Psychiatry, 47*(3), 206.

Sleek, D. (1980). The rights of mentally disordered children. *Victoria University of Wellington Law Review*, 317-330.

Slemon, A., & Dhari, S. (2024). Envisioning a safety paradigm in inpatient mental health settings: Moving beyond zero-risk approaches. *SSM-Mental Health, 5*, 1-8. https://doi.org/10.1016/j.ssmmh.2024.100315

Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing Inquiry, 24*(4), e12199. https://doi.org/10.1111/nin.12199

Smith, C. (2000). The sovereign state v Foucault: Law and disciplinary power. *The Sociological Review, 48*(2), 283-306. https://doi.org/10.1111/1467-954X.00216

St-Pierre, I., & Holmes, D. (2008). Managing nurses through disciplinary power: A Foucauldian analysis of workplace violence. *Journal of Nursing Management, 16*(3), 352-359. https://doi.org/10.1111/j.1365-2834.2007.00812.x

Stats NZ: Tatauranga Aotearoa. (2023). *2023 Census population counts (by ethnic group, age, and Māori descent) and dwelling counts*. New Zealand Government. Retrieved from https://www.stats.govt.nz/information-releases/2023-census-population-counts-by-ethnic-group-age-and-maori-descent-and-dwelling-counts/#:~:text=New%20Zealand's%20population%20continues%20to%20diversify&text=In%20the%202023%20Census%20we,8.9%20percent)%20as%20Pacific%20peoples

Stephanson, A., & Jameson, F. (1989). Regarding postmodernism--A conversation with Fredric Jameson. *Social Text, 21*, 3-30. https://doi.org/10.2307/827806

Stephens, M. (2001). A return to the Tohunga Suppression Act 1907. *Victoria University Law Review, 32*, 437-470.

Stumpf, J. (2006). The crimmigration crisis: Immigrants, crime, and sovereign power. *Amercian University Law Review, 56*, 368-419.

Surtees, N. (2011). Family law in New Zealand: The benefits and costs for gay men, lesbians, and their children. *Journal of GLBT family studies, 7*(3), 245-263. https://doi.org/10.1080/1550428X.2011.564945

Susser, M. (1958). *A report on the mental health services of the city of Salford for the year, 1958*. https://www.cabdirect.org/cabdirect/abstract/19602701889

Szasz, T. (1994). Psychiatric diagnosis, psychiatric power and psychiatric abuse. *Journal of Medical Ethics, 20*(3), 135-138. https://doi.org/10.1136/jme.20.3.135

Szasz, T. S. (1967). The psychiatrist as double agent. *Society, 4*(10), 17-24. https://doi.org/10.1007/BF03180072

Taitimu, M., Read, J., & McIntosh, T. (2018). Ngā whakāwhitinga (standing at the crossroads): How Māori understand what Western psychiatry calls "schizophrenia". *Transcultural psychiatry, 55*(2), 153-177. https://doi.org/10.1177/1363461518757800

Tamboukou, M. (1999). Writing Genealogies: An exploration of Foucault's strategies for doing research. *Discourse: studies in the cultural politics of education, 20*(2), 201-217. https://doi.org/10.1080/0159630990200202

Taylor, C. (2011). Biopower. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 41-54). Acumen.

Taylor, C. (2012). Foucault and familial power. *Hypatia, 27*(1), 201-218. https://doi.org/10.1111/j.1527-2001.2011.01171.x

Taylor, D., & Grey, S. (2014). From class-struggle to neoliberal narratives: Redistributive movements in Aotearoa/New Zealand. *New Zealand Sociology, 29*(3), 69-89. https://doi.org/10.3316/informit.898696652894448

Taylor, L. (1977). Aspects of the ideology of the gay liberation movement in New Zealand. *The Australian and New Zealand Journal of Sociology, 13*(2), 126-132. https://doi.org/10.1177/144078337701300206

Te Whatu Ora Health New Zealand. (2024). *Aotearoa New Zealand: Health status report 2023*. Author. https://www.tewhatuora.govt.nz/publications/health-status-report/

Tenorio, E. H. (2011). Critical discourse analysis, an overview. *Nordic Journal of English studies, 10*(1), 183-210.

The Royal Australian and New Zealand College of Psychiatrists. (2021). *Whānau ora*. Retrieved from https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/whanau-ora

Thom, K., Lenagh-Glue, J., O'Brien, A. J., Potiki, J., Casey, H., Dawson, J., & Glue, P. (2019). Service user, whānau and peer support workers' perceptions of advance directives for mental health. *International Journal of Mental Health Nursing, 28*(6), 1296-1305. https://doi.org/10.1111/inm.12637

Thompson, K. (2003). Forms of resistance: Foucault on tactical reversal and self-formation. *Continental Philosophy Review, 36*(2), 113-138. https://doi.org/10.1023/A:1026072000125

Thornley, D. (2001). White, brown or "coffee"? Revisioning race in Tamahori's "Once were warriors". *Film Criticism, 25*(3), 22-36.

Trnka, S., & Trundle, C. (2014). Competing responsibilities: Moving beyond neoliberal responsibilisation. *Anthropological Forum, 24*(2), 136-153. https://doi.org/10.1080/00664677.2013.879051

Tūpara, H. N. T. H. (2009). *He urupounamu e whakahaerengia ana e te whānau: Whānau decision processes.* [Unpublished doctoral thesis, Massey University]. https://mro.massey.ac.nz/items/753f8a94-eb8e-4195-9fea-869225663ff4

Turner, T. (2014). The legacy - or not - of Dr Thomas Szasz (1920-2012). *International Psychiatry, 11*(2), 48-49. http://www.rcpsych.ac.uk/pdf/PUB_IPv11n2.pdf#page=22

Ussher, J. M. (2017). A critical feminist analysis of madness: Pathologising femininity through psychiatric discourse. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 72-78). Routledge.

Van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & society, 4*(2), 249-283. https://doi.org/10.1177/0957926593004002006

Venkatesan, S., & Saji, S. (2019). Conjuring the 'Insane': Representations of mental illness in medical and popular discourses. *Media Watch, 10*(3), 522-538. https://doi.org/10.15655/mw/2019/v10i3/49683

Walker, R. C., Abel, S., Palmer, S. C., Walker, C., Heays, N., & Tipene-Leach, D. (2023). "We need a system that's not designed to fail Māori": experiences of racism related to kidney transplantation in Aotearoa New Zealand. *Journal of Racial and Ethnic Health Disparities, 10*(1), 219-227. https://doi.org/10.1007/s40615-021-01212-3

Walker, T. (2011). *'Whānau – Māori and family'* . Te Ara - the Encyclopedia of New Zealand. https://teara.govt.nz/en/whanau-maori-and-family/print

Wall, M. (1997). Stereotypical constructions of the Maori 'Race'in the media 1. *New Zealand Geographer, 53*(2), 40-45. https://doi.org/10.1111/j.1745-7939.1997.tb00498.x

Waller, S., Reupert, A., Ward, B., McCormick, F., & Kidd, S. (2019). Family-focused recovery: Perspectives from individuals with a mental illness. *International Journal of Mental Health Nursing, 28*(1), 247-255. https://doi.org/10.1111/inm.12528

Walsh, E. (2022). Memory, colonialism, and psychiatry. How collective memories underwrite madness. *Philosophy, Psychiatry, & Psychology, 29*(4), 223-239. https://doi.org/ 10.1353/ppp.2022.0040

Waring, M. (1997). The invisibility of women's work: The economics of local and global "bullshit". *Canadian Woman Studies/les cahiers de la femme, 17*(2), 31-38.

Waring, M. (2004). Unpaid workers: The absence of rights. *Canadian Woman Studies/les cahiers de la femme, 23*(34), 109-115.

Webber, M. (2005). "Don't be so feminist": Exploring student resistance to feminist approaches in a Canadian university. *Women's Studies International Forum, 28*(2-3), 181-194. https://doi.org/10.1016/j.wsif.2005.04.006

Whanau Ora Commissioning Agency. (2023). *Whānau ora: About us*. Retrieved from https://whanauora.nz/about-us

Wharehoka, T. (2021). Disability rights and compulsory psychiatric treatment: The case for a balanced approach under the Mental Health (Compulsory Assessment and Treatment) Act 1992. *Victoria University Wellington Law Review, 52*, 221-244.

White, R. (2009). Indigenous youth and gangs as family. *Youth Studies Australia, 28*(3), 47-56. https://go.gale.com/ps/i.do?id=GALE%7CA209103551&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=10382569&p=AONE&sw=w&userGroupName=tel_oweb&isGeoAuthType=true&aty=geo

Wilson, D., & Baker, M. (2012). Bridging two worlds: Māori mental health nursing. *Qualitative Health Research, 22*(8), 1073-1082. https://doi.org/10.1177/10497323124502

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing, 30*(23-24), 3539-3555. https://doi.org/10.1111/jocn.15859

Winch, S. (2006). Constructing a morality of caring: Codes and values in Australian carer discourse. *Nursing Ethics, 13*(1), 5-16. https://doi.org/10.1191/0969733006ne846oa

Wolman, B. B. (1961). The fathers of schizophrenic patients. *Acta Psychotherapeutica et Psychosomatica, 9*(2/3), 193-210.

Wolman, B. B. (1965). Family dynamics and schizophrenia. *Journal of Health and Human Behavior, 6*(3), 163-169. https://doi.org/10.2307/2948700

Woodard, W. (2014). Politics, psychotherapy, and the 1907 tohunga suppression act. *Psychotherapy and Politics International, 12*(1), 39-48. https://doi.org/10.1002/ppi.1321

World Health Organization. (1953). *The community mental hospital: Third report of the expert committee on mental health.* Author.

World Health Organization. (1962). *WHO and mental health 1949-1961*. Author.

World Health Organization. (2017). *Mental health atlas 2017*. Author. https://www.who.int/publications/i/item/9789241514019

World Health Organization. (2023). *Mental Health*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization and United Nations. (2023). *Mental health, human rights and legislation: Guidance and practice*. https://www.who.int/publications/i/item/9789240080737

Wyder, M., & Bland, R. (2014). The recovery framework as a way of understanding families' responses to mental illness: Balancing different needs and recovery journeys. *Australian Social Work, 67*(2), 179-196. https://doi.org/10.1080/0312407X.2013.875580

Wyder, M., Bland, R., McCann, K., & Crompton, D. (2018). The family experience of the crisis of involuntary treatment in mental health. *Australian Social Work*, 1-13. https://doi.org/10.1080/0312407X.2018.1454484

Zier, M. (2021). "Champion man-hater of all time": Feminism, insanity, and property rights in 1940s America. *Michigan Journal of Gender & Law, 28*(1), 75. https://doi.org/10.36641/mjgl.28.1.champion