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Navigating Mental Health Services as an (Im)Perfect Service User

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ABSTRACT

Purpose: This paper reflects on my experiences as a Māori woman navigating addiction, family violence, and recovery in New Zealand. The paper also explores how psychiatric and mental health nurses can better support women who use drugs (WWUD) by embracing complexity and rejecting idealized recovery models.

Background: WWUD who are also parenting and experiencing family violence face systemic stigma and exclusion from mental health and social services. Their experiences are shaped by intersecting barriers, including social judgment, fears around child protection, and a lack of appropriate services.

Methods: Using Frank's (1995) narrative typologies—chaos, restitution, and quest—I reflect on my lived experiences and draw insights from my doctoral research with mothers in a residential drug treatment and parenting program.

1 | Introduction

Drawing from my journey through addiction, family violence, and homelessness in Aotearoa (New Zealand) to my current role as a counsellor and researcher, this narrative challenges services and mental health clinicians to consider tāngata whaiora needs rather than expecting them to conform to rigid service structures. My experiences of social services—as a service user and provider—are demonstrative of the systemic barriers faced by women with complex needs, particularly mothers who use substances.

WWUD while parenting face harsh societal judgement, often labelled as "doubly deviant" (Malloch 2000, 55)—for transgressing both gendered expectations of motherhood and societal norms around drug use. This stigma impacts women more than men, as they also live with the constant fear of intervention by child protection services. This threat creates barriers to seeking and accessing help (Jackson et al. 2023).

My narrative explores these challenges through my lens as a white passing Māori (indigenous people of Aotearoa) woman, drawing parallels between my experiences and those of participants in my doctoral study. My study examined women's experiences of a 6-month residential drug rehabilitation and parenting programme that opened in Auckland in 2021. The programme, the first in Aotearoa to focus on the first 1000 days of a child's life, supports pregnant women or parenting women with a child under three.

Using Frank's (1995) typologies of chaos, restitution, and quest narratives, I examine how services can better support WWUD during their most chaotic periods, rather than waiting for them to become "ideal" service users. This narrative aims to inform mental health clinician practice and to advocate for more flexible and responsive services. In this article, "stories" and "narratives" are used as defined by Smith (2016). Narratives represent a person's life framework, whereas stories refer to specific events shaping that narrative (Smith 2016, 202).

Summary

- What is known on the subject
  - Research shows women who use drugs (WWUD) while parenting and experiencing violence face compounded stigma and discrimination from mental health and social services globally. These so-called "doubly deviant" WWUD are often denied family violence support, while addiction services fail to address their trauma and safety needs. Fear of child protection services creates additional barriers to seeking help.
- What this paper adds to existing knowledge
  - Using Frank's (1995) narrative typologies I examine how my lived experience can inform mental health service delivery. This paper demonstrates the importance of unconditional acceptance versus rejection in crisis moments. It challenges the "idealised recovery" narrative dominant in mental health and social services.
- What are the implications for practice?
  - Service providers and mental health clinicians must embrace complexity and chaos rather than expecting tāngata whaiora (people with lived experience of mental distress seeking wellness) to be "ready" or an "ideal" fit for services.
  - Rather than turning away those deemed "too complex," services and practitioners should create well-being pathways responsive to the needs of tāngata whaiora or refer them to appropriate services.
  - Mental health clinicians need education in substance use, addiction, recovery, and harm reduction to support marginalised populations, particularly mothers or pregnant women.
  - Service providers can benefit from incorporating peer support workers into clinical teams, valuing lived experience alongside professional qualifications.
  - Organisations, particularly addiction services, are encouraged to include trauma-informed approaches that address experiences of addiction, family violence, and complex mental health needs.

2 | Interpreting Experience: Frank's Narrative Typologies

In *The Wounded Storyteller* (1995), sociologist Arthur Frank analysed hundreds of illness stories and identified three common narrative typologies: chaos, restitution, and quest. Although Frank's work focuses on illness, these typologies also apply to addiction and recovery. They help us make sense of our experiences, articulate our struggles and hopes, and reflect on the transformations we undergo.

Chaos narratives are messy and fragmented. As Frank (1995) stated, you cannot tell chaos stories when you are in them—you can only make sense of them once you are out the other side. My chaos stories coalesce around addiction, family violence, and homelessness. In my darkest moments, I held no hope that things could get better. For the listener, chaos stories are hard to hear. They violate the human need for order (Frank 1995).

The restitution narrative assumes that people in addiction want recovery and that health is the norm, restorable. The restitution narrative reinforces the desire to get and stay well, but can feel disheartening or alienating when wellness remains out of reach despite a person's efforts. A common addiction narrative, it is shaped by institutional influences, such as rehabilitation programmes that dictate how addiction and recovery stories are told. Society amplifies this preference by wanting to hear restitution stories, following the arc: "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank 1995, 77). These stories can be told prospectively, retrospectively, and institutionally.

Frank (1995) described how a cancer support group, mostly in remission, subtly enforced a retrospective restitution narrative, sidelining a member's emotional account of current treatment. The group redirected the narrative to one of being "fine" to better align with their remission experiences. This reminds me of the 12-step meetings I used to attend. When you share, you are expected to follow a particular narrative formula: briefly share your experience (addiction story), then your strength (how you got abstinent, generally focusing on the benefits of the 12-step philosophy), and finally, hope (the positive changes to your life), all in under 5 min.

Quest narratives resonate deeply within the addiction community, featuring in our 12-step literature and celebrity autobiographies. They frame our journeys as inspirational, casting us as heroes who emerge from adversity. Narrators of quest stories share experiences of being unwell, what saved them, and how they transformed. In my experience, these stories are not just about overcoming addiction—they symbolise fundamental change, a shift from darkness to light. Frank (1995) suggested that quest narratives embody resilience, positioning the storyteller as someone who has 'risen from the ashes' with renewed purpose (122). I find Frank's (1995) description of moving from 'quest to testimony' (134) relevant, as it aligns with recovery ideology that emphasises sharing stories to support others. It's less about the lone hero and more about inspiring others. I relate to this shift, sharing my story only when it offers something of value to those in the mental health and addiction community.

3 | My Journey From Chaos to Quest

Thinking back to my experiences of homelessness, love, sex, violence, addiction, mental illness, and recovery, I see overlapping stories of chaos, restitution and quest. Although Frank (1995) associated these three typologies with illness, addiction often causes different aspects of life to converge. Although my stories are not all explicitly related to illness, they intersect and align with the three typologies. Today, standing on the other side of chaos, I can bring order to these stories.

Like me, the women who contributed to my doctoral research had asked for help long before entering residential treatment. However, either there were no services tailored to their needs, or they were rejected due to drug use. Like them, I reached a point of not knowing where to turn, having been repeatedly let down by organisations and state services. Unwilling–or unable–to reach out again.

My mental health was never in a good place given childhood trauma and other life events. As I got older, drug use and family violence became my reality. This severely reduced my ability to access services. The following stories involve some of my interactions with services and mental health clinicians.

In Aotearoa, there is a lack of services tailored to WWUD experiencing family violence; this trend is evident internationally (Kennedy et al. 2024). For WWUD, it is almost impossible to access family violence services—unless you lie. I understand why someone might hide their drug use from family violence services or downplay violence when seeking addiction treatment (Engender Equality 2024). Like the women in my study, I know how hard it is to access support when dealing with overlapping challenges. Not meeting the threshold or idealised notion of respectability renders you less deserving—an imperfect victim and service user—in the eyes of the service provider.

Perhaps it is easier to care about the more deserving victim? Someone, that is not an intravenous methamphetamine user trapped in a violent relationship, and a neglectful parent. My question to the people working in mental health and social services is: what level of imperfection are you willing to accommodate? If the criteria to access services excludes people due to complexities and coexisting problems, then I believe those services are inadequate.

4 | The Chaos Stories of the Imperfect Victim

From 35 to 39 years of age, I cycled through countless services—mental health programmes, hospitals, counsellors, police, three residential treatment services, community alcohol and drug services, and a psychiatric ward. Even though I began using substances at 12, it wasn't until, aged 37, in-between two residential programmes, that my deepest descent into chaos happened. I spent 9 months in my first residential treatment and was close to graduation. However, things derailed when I got into a relationship with another resident, and we absconded from the programme late one night. Six weeks later, we relapsed. Soon after, the violence began.

I reached out for help to many places over the years. However, I was unaware I would need to lie about my drug use to access family violence support. Honesty was my downfall. My first rejection was from a family violence service that provided support groups and counselling for women experiencing family violence. At this stage, I was functional, capable of engaging in coherent conversation.

After being upfront about my methamphetamine use, I was turned away. No offer of alternative help, no suggestions of addiction services. Not even a glass of water or a check-in about my safety. I stood there in shame, not allowed access to the space beyond, perceived as unworthy of help. Now, I see this as part of my story as the imperfect victim.

Another time, police asked me to collaborate in apprehending my violent on-again-off-again partner. I wanted out, so I agreed, perhaps seeing his arrest as my escape. I lured him to the house I was staying in, no doubt with the promise of drugs and sex. In the early hours, the police arrived, arrested him, and took him away. I was left alone with no support offered.

Unsure of what to do next I called a nationwide family violence service that operates women's refuge houses in Auckland. No help or support was provided. No one came to visit. No refuge was offered. Nothing. Then, 24 h after his arrest, he was released on bail. He came looking for me. I was back at square one. Worse, all I could think about was being 'stitched up' by the police after I collaborated with them. Where was the justice?

Even hospitalisation did not trigger an offer of support. During a week-long stay for a severe pelvic infection, my partner visited, angry and abusive. The staff witnessed this, heard his verbal abuse, saw my fear, but offered no support. No family violence screening, no social worker. Nothing.

The methamphetamine world is lonely. I disconnected from my wider family, rarely connecting with my adolescent daughter as I feared for her safety due to my violent partner. I lost healthy friendships and left an 11-year career under a cloud of shame and regret. Although I cannot recall all the details of those final weeks using drugs, I remember how it ended. My partner was arrested again, this time in a dramatic Armed Offender's Squad raid. A few weeks later, I woke up in ICU after 3 days in an induced coma due to a suicide attempt.

Luckily, I lived. Something shifted in that darkness—because when I woke up, I was offered, and accepted, help. In that moment my chaos story ended. I woke up in restitution. I said 'yes' to a stay in a psychiatric ward and shut the door on the methamphetamine world.

I received genuine care and empathy during my time in the psychiatric ward and within mental health services beyond the addiction space. The nursing staff in the psychiatric ward were kind and gentle. One of them even called the residential treatment centre for me because I feared being rejected. There was softness in those spaces—being fed, nurtured, and allowed to rest. At that time, it was exactly what I needed: space to feel cared for, accepted, and loved for who I was. It became a much-needed bridge into the more structured and challenging world of residential drug rehabilitation services.

5 | From Restitution to Reflection: Challenging the Perfect Recovery Story

My early recovery aligns with Frank's (1995) restitution narrative. Treatment services, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA) were the heroes in my story, and I was a walking advertisement for their success. My restitution narrative began when I entered residential treatment. My progress followed a linear path which I met both programme and societal expectations—becoming an abstinent addict and redeemed. Yet, the restitution narrative is problematic; it places unrealistic expectations on tāngata whaiora to comply with organisational ideas about what treatment—and wellness—should look like.

I completed a second residential treatment and spent 10 months in a residential support service. For 5 years, I attended NA and

AA meetings, engaged in group work and one-on-one counselling. My recovery journey was in full flight; I was a success and viewed my pathway as attainable for everyone. The recovery story is seductive—for both the teller and the listeners: family, others navigating recovery, and even helping professionals with a moralistic lens. It becomes a powerful meta-narrative, one I consumed and regurgitated to others: I did it. Therefore, you can.

A decade later, during my PhD fieldwork in a mothers' and babies' unit, I had an epiphany. I realised their restitution stories were not my story, nor anyone else's. Others' journeys were diverse, different from mine. I understood graduation from residential treatment was not the ultimate "success" story. The treatment centre was just one link in my chain of wellness.

After treatment, I started my life again. I washed dishes for the minimum wage and began to study. I found my way into a social work degree, determined to avoid working with people like me—those in addiction. Six years after completing my second residential treatment, I returned as a community counsellor. I needed those years away from anything addiction-focused to make peace with my story and to see it as a strength within my practice rather than a source of shame.

My view of recovery changed after leaving that counselling role and transitioning into independent, trauma-informed practice. I no longer believe in a higher power and have returned to my atheist beliefs. I no longer believe that 12-step meetings are fundamental to my abstinence, or that relapse is inevitable if I stop going. I do not see abstinence as the only option. I now understand that individual choice and harm reduction are valid, sometimes preferable, options. I understand that people who still use substances problematically deserve service support, respect, and a right to live in dignity. Those who remain in, or are unable to escape, their chaos stories are worthy of support.

Today, I work in spaces where harm reduction is supported. People are seen as worthy, regardless of whether they meet an idealised notion of 'suitable client'. I've learned that wellness is whatever is meaningful and possible for the individual. I know too that a service provider's personal lens can obscure the structural barriers people face. Too often, our services are not designed for the complexities and vulnerabilities of those most in need.

For instance, when health and social services are not designed with the needs of diverse communities in mind, they can reflect and reinforce institutional racism. This contributes to significant access barriers for Māori (Jackson et al. 2023), as well as for other Indigenous peoples and minority ethnic groups. There is also a lack of gender-specific services, particularly for pregnant people and parents (Jackson et al. 2023; Kennedy et al. 2024). In addition, services for family violence, mental health, and addiction generally remain siloed, making it difficult for people with intersecting needs to access support.

Many people are shut out of healthcare due to cost or long waitlists. Services for rainbow communities, youth, and people with disabilities are limited. Even when cultural or population-specific services exist, many are underfunded and can notmeet demand.

Preconceived ideas—shaped by labels like 'addict'—influence the care people receive. Many health and social service workers form narratives based on past presentations, race, gender, and assumptions about addiction, mental illness, and recovery. However, we cannot truly know someone's story. And assumptions, made from fragments like "who's trying hard enough, ready for change, just seeking drugs, or deserving care", become institutional stories and gatekeepers, determining who gets access to care and who gets turned away.

6 | Quest: Parental Reckoning & Cultural Connection

If restitution stories are intervention-driven, then quest stories are self-driven. Quest stories are where my self-belief and internal drivers took hold. However, it would be arrogant for me to assume I no longer needed support. I continued psychotherapy for many years—in fact, I was well into my eleventh year of recovery before stopping weekly counselling. Therapy gave me space—free from substances—to unpack childhood and drug-related trauma.

I cannot ignore that my transition from chaos to quest was challenging for unwitting passengers, particularly my daughter. I had to face my shame of being what I considered a 'shit' parent. Over time, I was able to reject societal expectations of "good" motherhood while also taking responsibility for what I could have done differently.

An addiction quest story involving motherhood also involves a child. Now that my daughter is 31 and a parent herself, I question whether this story is mine to tell. Her role as narrator is pivotal. My memories are likely hazy—from substance use or perhaps deliberate forgetting.

As Dreyfus and Rabinow (1982) recount from a personal communication with Foucault, "People know what they do; they frequently know why they do what they do; but what they don't know is what they do does" (p. 187). I argue that, in my experiences of the methamphetamine world, I neither knew what I was doing, nor why I was doing it. Making sense of my behaviour and its consequences has taken years. Stepping outside my own and society's restrictive recovery mindset enabled deeper reflection. I may never find redemption—in my eyes, my daughter's, or society's.

But because my grandson was born after I stopped using substances, he weaves easily into my restitution and quest narratives. My daughter told me she was pregnant during my second residential treatment. When my grandson was 3 months old, I moved in with them and stayed until he was six. Much to my and my daughter's surprise, I became an integral part of their lives. My quest narrative evolved. I may have been a 'shit' mother, but I'm now a fantastic nana. I wonder how this sits with my daughter. I unpack my parenting journey in more detail in my thesis, exploring how mothers weave parenting into addiction and recovery narratives.

Another part of my quest story has been reclaiming my identity as a Māori woman. I am white passing and spent most of my

life disconnected from te ao Māori (the Māori worldview), which created a complex relationship with my cultural identity and initially made it challenging to claim my place within the Māori community. However, through attending a drug treatment service with a meaningful bicultural (Western and Māori) programme, I began reconnecting to who I am and to my whakapapa (ancestral family connections). I approached treatment as a shared journey, opening up to staff and fellow residents as whānau (extended family) and participating in cultural practices like karakia (prayer) and waiata (song)—rituals that once felt foreign but now gave me a sense of belonging. Grounded in Māori principles, I started to see myself not as a "patient" being treated, but as a Māori woman reclaiming my mana (dignity and strength) and walking alongside others on a collective path to wellness.

Through this journey of reconnection with my Māori heritage, my understanding of recovery has been reshaped. Although in this treatment centre, I learnt my pepeha (I introduce myself in Māori which connects me to my ancestors and land) and began learning te reo (the Māori language), which helped me reconnect to my whakapapa (ancestral family connections) and tūrangawaewae (a sense of identity and independence associated with knowing my homebase). Over the 18 weeks in the programme, I learnt the karanga (ceremonial call of welcome) and had the honour of opening the pōwhiri (welcome ceremony) space to new residents. I also led the female part of the recovery haka (ceremonial war dance). These experiences built my confidence and self-belief. I learnt about Māori cosmology and the atua (gods) and spent time on the marae (tribal meeting grounds), connecting with peers and staff in ways that felt softer and more strength-based than the often rigid structure of treatment. I experienced aroha (love, compassion) through cultural connection—something that transcended the boundaries of treatment and continues to shape who I am. This journey lit a fire in my belly to keep learning tikanga (customs), te reo, and Māori wellbeing frameworks that I can carry into my practice. Cultural reconnection has shown me that recovery is not just about abstinence, but a holistic healing of body, mind, and spirit, grounded in community, identity, and love.

My current understanding of recovery is different from where I started. No doubt that will shift the more I work and continue learning. My lived experience, work in mental health services, and research have provided insights into the barriers we create and the people we exclude.

7 | Quest Testimony: Bridging Lived Experience, Education and Professional Practice

The pursuit of education has been a central story within my quest narrative. I left school at 15 with no qualifications. In recovery, I realised I wasn't stupid as I'd been led to believe through early disconnection from school, and that I could excel in higher education. I have spent the past decade studying, earning an undergraduate degree and master's in social work. I am now close to finishing my doctorate. Being part of the university world has meant more to me than just being a student. It provides structure to my days, a way to participate in life, and to do something meaningful with a hopeful outcome. It has been a purposeful place to land after existing in many hopeless places.

My time working as a community researcher—in a residential treatment service where I was once a resident—has shown me how research can improve service delivery. In a recent project, I explored why people leave residential treatment early and what helps them stay. This research helped me—and the provider—understand how services often fail those with complex problems and trauma.

My abstinence is a core part of my personal and work-life narrative. Being 11 years clean and sober carries weight—it is a selling point within my mental health work and adds credibility to my research. Selfishly, it serves me. However, working with the women in my study has shown how pushing this 'idealised recovery' story can stop people getting help when they need it.

When I first met the women in my doctoral project, I shared just enough of my story so they knew I had been in similar places. This reciprocity mattered—my understanding of the methamphetamine world created a connection that made it easier for them to share their stories. Listening to them helped me think of my own and others' stories differently.

In my research on improving services, I draw on both my lived and clinical experience to dig deeper. How can services bend to fit complex needs? What happens when we make room for different recovery paths? We need more nuance in the stories that are told—and valued—within services. Getting well is not a one-size-fits-all solution, and nor should our support be.

8 | Navigating Broken Systems: A Provider's Perspective

Mental health nurses are often the first point of contact for tāngata whaiora. Their ability to build rapport, interpret cues, and hold space during distress uniquely positions them to "hold chaos" in clinical and community settings. Addiction practitioners and services can learn from this approach. Yet mental health nurses, addiction practitioners, social workers, and counsellors all operate within—and are often constrained by—broken systems. In both research and practice, it's clear these systems not only fail service users but can cause harm. Patriarchy, racism, neoliberalism, and capitalism shape the conditions we face. These forces underpin services and shape daily practice.

The current global context amplifies these challenges. Rising authoritarianism, widening inequity and escalating environmental crises leave us providing increasingly complex care to more people, with fewer resources. Addiction and mental health services aren't exempt from these forces of oppression and underfunding. Although I urge practitioners to give the best care possible, I know we're fighting an uphill battle against deeply entrenched structural barriers.

My social work education and lived experience have helped me navigate systemic challenges and bridge gaps between services. In Aotearoa, I have developed an understanding of

services operating within Western and kaupapa Māori frameworks (grounded in Māori values, principles, and worldviews) (Wirihana and Smith 2014). I often straddle these approaches, working across silos to connect people to the support they need. When I can notprovide help directly, I link people with others who can. Our role is to support tāngata whaiora through broken systems on their quest for wellness.

9 | Recommendations Informed by My Personal Experiences

9.1 | The Hospital Experience

To the woman in the emergency department who sat with me after an earlier suicide attempt—thank you for telling me I was beautiful and holding my hand. Thank you for not making me feel like I was wasting hospital time or space.

9.1.1 | Recommendation

Emergency departments need to provide unconditional acceptance and 24/7 mental health crisis support. Staff need training in trauma-informed care. Every person deserves dignity, no matter how they arrive at services.

9.2 | The Psychiatric Ward Experience

Thank you to the psychiatric ward for letting me do my jigsaws, feeding me, letting me sleep when needed, and helping me return to residential rehabilitation.

9.2.1 | Recommendation

Healing is not always about doing—sometimes it's about being. Mental health services should create spaces where people can rest, eat, and engage in simple activities without pressure or expectation. This space for rest is crucial for recovery. Addiction practitioners and services have much to learn from mental health nurses, particularly in how they create safety through consistent engagement, de-escalation, and calm, relational presence.

9.3 | The Rehabilitation Journey

Thank you to the woman in rehabilitation aftercare who shared about losing her brother to suicide. Your vulnerability stayed with me. It may not have stopped my mental health decline, but it resonated.

9.3.1 | Recommendation

Services need to embed peer support at every level. These connections reach people in ways clinical interventions cannot. Peer workers should be valued equally with clinical staff, properly paid, and supported. Their lived experience is a qualification no training can replicate.

9.4 | The Education Journey

Thank you to the lecturer who supported my admission into social work when I was in early recovery. This started my learning journey, and while social work education lacked addiction knowledge, I had my lived experience to draw upon.

9.4.1 | Recommendation

Mental health nursing, counselling, and social work qualifications must include addiction and recovery education. Mental health nurses must be trained to work across Indigenous frameworks, including how to engage with families and communities, uphold the principles of self-determination, and respond to the impacts of colonisation and systemic racism in care delivery. Practitioners need stronger training, supervision, and cultural support, especially when working with Māori and Indigenous communities.

10 | Final Thoughts

Looking back at my chaos, at moments where services either held me or pushed me away, I see how the system struggles with imperfection. We claim to provide trauma-informed care but still expect people to show up clean, sober, and ready for change. Chaos does not work like that. My journey from methamphetamine user, imperfect victim, and complex client to counsellor and researcher has shown me that service providers and clinicians must change.

We must break down silos between addiction, mental health, and family violence services because people's lives are complex, and they need joined-up support. As highlighted by one study from the New Zealand Family Violence Death Review Committee, there is a need to "develop and resource equitable mental health and addiction practices that are responsive both to people experiencing and using violence, and to their families" (Short et al. 2019, 1209). Family violence screening should be standard in mental health and addiction services, with pathways that do not force people to choose between help for violence, and addiction. We also urgently need family violence services that support people who use drugs.

I see myself in the women in my doctoral study. They are at the apex of need, carrying multiple labels, fighting systems that expect them to be perfect mothers while dealing with addiction, trauma, family violence, and punitive services like Oranga Tamariki. Parents, especially those who are pregnant, should get support that helps them heal without fearing child removal. Without moments of genuine human connection—my hand held in hospital, stories shared in treatment, the lecturer who saw past my history—I would not be here writing this.

If we help only tāngata whaiora who meet our criteria—the 'easy,' 'ready,' and 'stable'—we fail those who need us most. We need services that can hold chaos, meet complexity, and see the person behind the labels. So, I'll keep asking: what level of imperfection are we willing to accommodate in our services?

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The author declares no conflicts of interest.

Data Availability Statement

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