



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Research Commons

<http://researchcommons.waikato.ac.nz/>

Research Commons at the University of Waikato

Copyright Statement:

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

The thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognise the author's right to be identified as the author of the thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from the thesis.

**Realising Our Best Intentions: Vision, Values and Voice in
the Community Non-government Organisations of the
Aotearoa\New Zealand Mental Health Sector**

A thesis submitted in fulfilment
of the requirements for the degree

Doctor of Philosophy

in

Management Communication

at

The University of Waikato

by

Kirsty Frances Mary Barber



THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2015

Abstract

This thesis examines the effectiveness of establishing a recovery orientation in community, non-government, mental health organisations in Aotearoa\New Zealand. It addresses the discursive constructions of key concepts such as madness, recovery and community care. In addition, it examines the wider, societal and institutional pressures that influence how important features of a recovery discourse, such as empowerment and an ordinary life in community, are articulated and enacted within organisational environments. It also investigates how institutional hegemonies are contested, and opportunities identified for institutional change and organisational transformation.

Critical and postmodern perspectives in healthcare provided a rationale for utilising the framework for organisational communication research, developed by Dennis Mumby and Cynthia Stohl (1996, 2007). The framework addressed the problematics of (1) voice, (2) rationality, (3) the relationship between organisations and the state, as well as (4) the problematic of organising itself.

Critical Appreciative Inquiry (Grant & Humphries, 2006) was the methodology used for this project. Focus groups and interviews facilitated dialogue among support workers, team leaders and senior managers from a range of community mental health organisations throughout Aotearoa\New Zealand. These encounters encouraged conversations about what worked well in organisations, and how to enhance a recovery-orientation, without shying away from a critical analysis of what was impeding best practice. The dialogues also enabled examination of how these organisations were situated within the larger socio-political and cultural environment.

The findings of the study showed that organisational stakeholders constructed and translated the discourses of madness, illness and recovery very differently. Translations reflected the relative power of particular discourse communities, with powerful groups able to control meaning systems through their greater social legitimacy. Institutionalised discourses of biomedicine and managerialism proved

difficult to “deinstitutionalise”, and institutional agents “translated” recovery discourses in ways that ensured little disruption to powerful and privileged interests. In addition, it was apparent that institutions undertook defensive institutional work when challenged. Defensive strategies were primarily discursive, e.g. translation, but were important mechanisms through which institutional interests subsumed alternative discourses, and maintained power over an organisational field.

This thesis contributes to the field of organisational communication by demonstrating that perceptions of organisational, and institutional change, are frequently discursive, rather than substantive. Effective organisational change, therefore, needs to challenge institutional structures and systemic relationships of power. Sustained, and sustainable, change requires fundamental shifts in the rational bases of institutional logics. This has important implications for how less powerful actors and organisations can establish alternative discourses in institutionalised fields, such as mental healthcare.

Acknowledgements

My first, and foremost, acknowledgement is to Professor Shiv Ganesh without whom this project would, truly, have not been completed. He has cajoled, challenged and argued with me in turn, but has remained committed and engaged throughout. Shiv is a generous host, a wonderful friend and an incomparable mentor.

Shiv's knowledge of the field of organisational communication, and scholarship in general, is truly eclectic. Whenever I became stuck, theoretically or conceptually, he referred me to papers or scholars that invariably resolved the impasse and generated the quantum leap needed to promote new thinking and deepen my understanding. His guidance has been infallible.

My heartfelt gratitude is also due to my other supervisors, Professor Kay Weaver and Dr. Alison Henderson. Both have been very patient and I am particularly appreciative of Kay's meticulous eye and grateful for her well-disguised frustration at my incapacity to manage details. I am equally grateful to Alison, for her continuing encouragement and positivity throughout a journey that proved to be much longer than any of us originally anticipated.

I also need to thank my participants. I have been privileged to share their stories. Without exception, they exhibited huge commitment to the sector and to the people whose lives they encounter, purely because of the difficult human experiences of serious psychological distress. Because of them, I have optimism about the transformation of the community mental health sector.

Thanks to Angela, Amanda, Gwenda and Judith for all their friendly advice and competence over the years, about transcriptions, scholarships and administrative processes. And many thanks, too, to Anne Kennington who cheerfully provided another pair of eyes and ears whenever I needed it.

For Claire and my father

TABLE OF CONTENTS

Abstract	i
Acknowledgments	iii
Chapter 1: Introduction	1
Chapter 2: Background and history	11
Introduction	11
Table 1: Chronology of significant events in organising of mental health services in Aotearoa\New Zealand	13
From Bedlam to Tokaanui: The age of the asylum.....	23
1900s to 1950s: The age of the psychiatric hospital	27
1950-1970: The social phenomenon of “deinstitutionalisation” and being out in the “community”	32
1970s: The second wave of deinstitutionalisation	37
1980s: The growing tide of unrest.....	40
1990-1996: A period of reforms.....	44
1996- 2000: Recovery, a new discourse emerges	52
2000-2014: Recent issues and important trends	59
Conclusion	64
Chapter 3: The theoretical terrain	69
Introduction	69
Fields of interest	72
The critical gaze on healthcare	72
Conclusion	82
Chapter 4: Literature review	85
Introduction	85
The problematic of rationality in mental health and psychiatry.....	87

The problematic of the relationship between mental health organisations and society.....	98
The problematic of organising of mental health care	115
The problematic of voice in mental health organising.....	150
Conclusion.....	168
Chapter 5: Research design and methodology.....	173
Introduction	173
Methodological stance	174
Research design and methods.....	183
Procedures for participant recruitment and data collection	189
The organisation and analysis of the data.....	196
Conclusion.....	205
Chapter 6: Lost in translation: Negotiating the discourses of recovery	207
Introduction	207
Stories of madness.....	208
Stories of recovery.....	217
Living an ordinary life in community	232
Organising recovery: Relationships, roles & outcomes.....	241
Lost in translation: Conflicts and tensions.....	262
Conclusion.....	270
Chapter 7: Encountering the institutions	275
Introduction	275
Normal and natural: Societal assumptions, myths of deinstitutionalisation, and the normative institutional pillar.....	276
Enduring and persistent: The cognitive pillar and bodies of knowledge	289

Legitimation and authority: The legislative pillar and relationships of power	307
Conclusion	319
Chapter 8: Fighting back: struggles, challenges and innovation.....	323
Introduction.....	323
Subordination and insubordination: Taking on the institutions	324
The times they are a changin': Trying to do it differently.....	340
The empire strikes back: Counter challenges and defensive institutional work	356
Conclusion	370
Chapter 9: Discussion and conclusion.....	373
Discussion of findings	375
Implications: Practical, theoretical and methodological.....	385
Limitations	391
Future directions and possibilities	393
Appendix 1: Summaries of participant demographics.....	399
Appendix 2: Focus group questions.....	405
Appendix 3: Pre-focus group participant forms	407
Appendix 4: Post-focus group participant forms.....	409
Appendix 5: Textual data	411
Appendix 6: Preliminary data from pre and post focus group forms	413
Appendix 7: Emergent themes	415
Appendix 8: Initial impressions, preliminary findings and emerging themes	417
Appendix 9: Glossary of terms, abbreviations and acronyms	423
References	425

Exhibit D

Here is my brain

in a pickling jar.

Note the tired synapses.

Observe the threadbare nerves.

Then tell me, if you will

where is my love of rain

my craving for colour

my vanishing dream?

Healing is about connection not control

Julie Leibrich

Chapter 1: Introduction

Throughout history and across cultures people experiencing serious mental and emotional distress have been perceived as troubling for the communities in which they lived (Canguilhem, Cohen, & Foucault, 1989; Drake, Green, Mueser, & Goldman, 2003; Leibrich, 1998). “Mad” or “bad” they have had their problems defined by the dominant institutions of their contemporary social order (Bracken & Thomas, 2001; Fisher, 2000; Pearson, 2000; Samson, 1995; Scull, 1993). All too frequently they have been alienated from society and systematically dehumanised through loss of personhood, human rights, and civil protections. Many have been subjected to a range of social, moral and scientific controls and experimentations that have largely been unchecked or ignored by other members of their societies (Bracken & Thomas, 2001; Foucault, 1963, 1973; Grob, 1994).

Over time a variety of explanatory models for serious psychological distress have evolved; not only framing the discourses of mental health and mental illness but also producing their own preferred approaches to care, treatment and support of vulnerable people (Anthony, 1993; Barber, 2005; Jacobson & Greenley, 2001; Lapsley & Nikora, 2002; Pilgrim, 2002; Rapp, 1998; Rappaport, 1987). Scientific, or biomedical, models have become increasingly dominant in Western mental health systems over the past two centuries (Bracken & Thomas, 1999; Pilgrim & Rogers, 1999). However, over several decades there have been attempts to introduce more humanistic paradigms into the field. These alternative paradigms have shared a belief that a life worth living is a fundamentally different goal to the “cure” of mental illness (Deegan, 1996; Leibrich, 1997, 2000a, 2000b). The foremost of these, in Aotearoa\New Zealand, has been *recovery* (Anthony, 2003; Banks, Burdett, Burnett, Christensen, Crooks, & Edwards, 2004; Bonney & Stickley, 2008; Lapsley & Nikora, 2002; O’Hagan, 2004; Pearson, 2004; Platz, 2006).

Aotearoa\New Zealand is credited with leading the world in positioning the concept of recovery as the rational basis for guiding the development of all mental health service policy and delivery (O'Hagan, 1999; Adams, Daniels, & Compagni, 2009). It was this model that underpinned the publication of *The Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission, 1998) based on the assumptions that all people have a right to their aspirations for well-being and quality of life, and the personal power to make the important decisions about their lives. In addition, the recovery model, affirmed in *The Blueprint*, acknowledged that all members of a community have a right to participate fully in that community and have equitable access to its resources and opportunities.

With the publication of *The Blueprint* opportunities arose for new subject positions in the sector as well as innovative approaches to care and support (Banks et al., 2004; Gawith & Abrams, 2006; Goldsack et al., 2005; Harrison, 2010; Lerner & Craig, 2005; McMorland et al., 2008; Peters, 2009, 2010). In particular, formal recognition of recovery provided people with lived experiences of serious psychological distress, their families and allies with a voice in various forums engaged in the development of the sector. In other words, recovery had political as well as personal implications from its inception in the Aotearoa\New Zealand mental health sector (O'Hagan, 2004).

The Blueprint also acknowledged the important, but currently undervalued role, of the community non-government organisations (NGOs) (Harrison, 2010; Mental Health Commission, 1998; Peters, 2010). These organisations, potentially, were advantageously positioned to deliver recovery-oriented services that resonated with their constitutions, missions and values. They typically aspired to a more humane and socially equitable society and had their own character; one that has not been represented in the domain of corporate organisations or well explored within the field of organisational communication (Lewis, 2005).

Creating a robust community sector, therefore, seems to be a logical and important step in enhancing people's capacity to live well in desirable

environments (Barber, 2005; Harrison, 2010; Mental Health Advocacy Coalition (MHAC), 2008; Peters, 2010). Guided by strong social values and, more recently, the recovery model, the community mental health non-government organisations (NGOs) have, like most publicly funded social services, nevertheless been subject to the vicissitudes of the socio-political climate (Fougere, 2001; Ganesh, 2005; Harrison, 2010; O'Brien, Sanders, & Tennant, 2009). Not only vulnerable to socio-cultural and political tides they have been financially dependent on, and treated as subordinate to, clinical mental health services.

In addition, ideological and policy shifts over successive governments, which led to massive reorganising of the entire Aotearoa\New Zealand health system in the 1990s (Ashton, Mays, & Devlin, 2005; Boston, Dalziel, & John, 1995; Davis & Ashton, 2001), has meant that community NGOs have struggled to establish themselves politically as legitimate and credible alternatives to clinical care. These tensions seem to have substantively constrained the capacity of the NGOs to engage creatively with, and respond effectively to, changes in their internal and external environments, thereby “realising their best intentions” (Barber, 2005).

In Aotearoa\New Zealand, as elsewhere, proponents of recovery, and related discourses of strengths-based and solution-focussed practices, have long argued for system transformation founded on a robust and clearly articulated philosophy and values base of empowerment, community life and resourcefulness (Banks et al., 2004; *Central Potential*, 2008; Chamberlin, 1998; Curtis, 1997; Deegan, 1998; Lapsley & Nikora, 2002; McCashen, 2005; Mental Health Commission, 1998; Rapp, 1998; S. Rose, 2000; Warriner, 2001). Many have been optimistic about the opportunities these approaches have envisaged for people living successful and meaningful lives in the communities of their choice (Banks et al., 2004; Barber, 2005; Caird, 2001; Gawith & Abrams, 2006; Leibrich, 1998). My own Masters research project *It Ain't Rocket Science* (Barber, 2005), for example, provided some wonderful stories of successful community living, great strengths-based and community focused initiatives and identified

some very good community practitioners in the sector. However, it was equally apparent that these ways of working were not being formally embedded in organisational talk and practice. In fact, it seemed that these workers were practising in recovery-focussed ways, *despite* their organisational systems and practices.

The rhetoric of service quality and philosophy in Aotearoa\New Zealand has conveyed a sense that the mental health system is constructed entirely to support a person's needs, aspirations and rights to self-determination. However, pragmatically, realising these ambitions has been an ongoing struggle in the face of other, more powerful, stakeholder interests (Davidson et al., 2007; Kendrick, 2004; Warriner, 2001, 2010). Therefore, many are now concerned that the mental health sector has not fully engaged with processes of organisational and institutional transformation; instead displaying a tendency to merely re-label existing services as recovery oriented (Anthony, 2003; O'Hagan, 2004; Pearson, 2004; Ridgway, 2001).

Additionally, there appear to be many notable gaps in the research, and literature, around what constitutes best practice and effectiveness in a recovery-oriented mental health system. Given that Aotearoa\New Zealand is credited with being the first country in the Western world to formally adopt recovery as policy, these gaps indicated to me that this current project is timely and important for the mental health sector in Aotearoa\New Zealand (Barber, 2005; Lapsley, 2004; Lehman, 2000; Mental Health Commission, 2011b; O'Hagan, Reynolds, & Smith, 2012; Pearson, 2001; Ramon, Healy, & Renouf, 2007).

First, mental health research has paid scant attention, and even less funding, to the social dimensions of recovery and other sociological models (Bonney & Stickley, 2008; MHAC, 2008; Minkler, 2000; Pilgrim & Rogers, 1999; Pincus, Henderson, Blackwood, & Dial, 1993; Rappaport, 1990, 1995). There has been a similar paucity in critical research focussed on the social impacts of mental disorder, as ideological products of social inequity, which have excluded people from society and restricted their lives much more than the symptoms of illness.

Second, there has also been little scholarly attention paid to the not-for-profit organisations, of which the NZ community mental health NGOs are representative. Partly this appears to be due to the general political vulnerability of organisations associated with low paid, low status and, predominantly, women's work (Cheney & Ashcraft, 2007). Added to the evidence that mental health is usually not politically "sexy", the contribution of the community sector to social well-being has largely been undervalued and its potential untapped.

In addition, as several critical scholars have noted, ordinary workers have typically been removed from the academic gaze (Ackroyd & Thompson, 1999; Broadfoot & Munshi, 2007a; Mumby, 2005). Consequently, there has been little recognition of the opportunities for creative struggle and resistance, which might indicate pathways for transformation into alternative organisational realities (Adams et al., 2009; Laughlin, 1991; Lord, Ochacka, Nelson, & Choma, 2004; Shaw, 2002; Trethewey & Ashcraft, 2004). Equally, there has been little research on mechanisms for the disruption, destabilisation and deinstitutionalisation of powerful, discursively naturalised and socially legitimised institutions such as biomedicine and managerialism (Clemente & Roulet, 2015; Maguire & Hardy, 2009; C. Oliver, 1992). There has been even less research on the defensive work that institutions undertake in the face of threat and challenge to their socially embedded authority and status (Lawrence & Suddaby, 2006; Maguire & Hardy, 2009; Reay & Hinings, 2005).

It seems important, therefore, that the community mental health organisations, as a sector, be able to identify and articulate their own best practices in recovery and have a voice in the development of outcome measures that capture, meaningfully, the aspirations of people who use their services. These objectives required a theoretically critical approach to investigate, and interrogate, what constitutes effective organisational practices within the community mental health sector in Aotearoa\New Zealand, and, in particular, the ways these services are fulfilling expectations that they should be recovery-oriented within both their organisational practices and their service outcomes. These intentions were particularly significant for a non-government organisation

sector framed as “alternative” to institutionalised biomedical orthodoxy, and embedded in the asymmetrical power relationships of contemporary social systems and organisational arrangements. In particular, it was important to cultivate the discourse of academic suspicion about “value free”, “neutral” and “objective” positivist science.

My motivations for this research were threefold. First, an unintentional outcome of my Masters research (Barber, 2005) was a clear frustration, expressed by participants from community mental health organisations, with the tension between the expressed goals and values of organisations and an unwillingness to recognise the logical consequences of that in terms of the redistribution of power and resources (Barber, 2005; Labonte, 1996). Participants were clearly making a significant and positive difference in the lives of service users, but were frequently unsupported by organisational, service and policy environments that treated them as inconsequential. It appeared that major systemic and organisational transformation was required in the mental health sector for recovery aspirations to become realities for people with experiences of serious psychological distress.

Second, these organisations did not appear to be systematically realising the intentions of their mission statements and professed values base despite great stories of successful outcomes (Barber, 2005). Third, these circumstances echoed gaps in, and ideas emerging from, the literature - particularly those texts authored by people with their own experiences of psychological distress - that suggested recovery was proving difficult to achieve in practice, and now risked becoming fatally compromised.

Consequently, I developed a methodological approach that facilitated dialogue about what was already working well in terms of recovery-oriented organisational talk and practice, and how this could be enhanced, without shying away from a critical appraisal and analysis of what was impeding or constraining best practice (Grant & Humphries, 2006). My overriding objective was to better understand processes of organisational transformation and the emerging identity of the community mental health NGO sector, as it moves towards

enacting a paradigm shift, to become effectively recovery-oriented (Lord et al., 2004; Nelson, Lord, & Ochaka, 2001; Pearson, 2000, 2004).

To this end, I developed three research questions for this doctoral research study. The first question asked, “In what ways are discourses of recovery constructed, negotiated and resisted in everyday practice within non-government community mental health organisations in Aotearoa\New Zealand?” This question was concerned with addressing the meanings of recovery and related concepts from a variety of perspectives and occupational groups in a range of organisations throughout the country. I was interested to identify and conceptualise dissonance, tensions and frustration, and examine how participants were managing these. As well as uncovering how recovery was being framed, I was interested in what people and organisations were trying to *do* in terms of recovery, and how it was being transferred into practice.

My second question was concerned with evidence of the influence of other, especially institutional, discourses in participant talk and important texts; specifically, “How are institutional dynamics working to construct, constrain or contradict organisational practices in terms of becoming recovery-oriented?” I wanted to examine how external, societal pressures were infiltrating organisational environments and the extent to which they were directing organisational communication and practices.

Third, I wanted to understand the extent to which participants were conscious of multiple discourses of mental health and mental illness, and the ways in which they attempted to resolve or resist the tensions between them. In particular, I wanted to identify the ways in which participants might challenge powerful discourses, articulate the struggles that were apparent and what innovation they considered was possible. Therefore, the third research question asked, “In what ways are institutional dynamics being problematised and challenged within these organisations and to what effect?”

Having outlined the motivations behind this research, and the research questions, what follows is a structural outline of the thesis, briefly describing the content and purpose of each chapter.

Chapter 2, *Background and history*, is a theoretically literate exposition of the Aotearoa\New Zealand experience. This is grounded in a Foucauldian informed narrative of the important historical and socio-cultural influences on Western mental healthcare systems generally (Foucault, 1963, 1970, 1972, 1973). Specifically, the chapter establishes how normative, political and ideological assumptions have woven the fabric in which contemporary mental health organisations in Aotearoa\New Zealand are embedded.

In Chapter 3, I examine the specific set of theoretical commitments that underpin this research and which guides the analysis. In doing so, I cultivate a discourse of academic suspicion about “value-free”, “neutral” and “objective” science as it engages with the deeply personal and communal experiences of serious psychological distress. In this chapter, I also discuss the various academic fields, such as medical sociology and health communication, which have challenged the orthodoxy of mainstream biomedicine and psychiatry.

Following this theoretical discussion, Chapter 4 provides a critical analysis of the literature that underpins how mental health care in Aotearoa\New Zealand is organised. I have structured this review around the four problematics for critical organisational communication studies proposed by Dennis Mumby and Cynthia Stohl (1996, 2007). These problematics (namely organising and the state, rationality, organising and voice) provided a comprehensive framework for exploring the complex weave of societal, rational and organisational factors that have historically impacted on the treatment and care of people experiencing psychological distress.

In Chapter 5, I describe the research design and methodology used in the project. Critical Appreciative Inquiry was used to tease apart apparent discourses of recovery and related concepts, as well as to discern the relative power levels at which they functioned within these organisations. Participants were organised into cohorts, reflecting their organisational roles and responsibilities. Focus groups and interviews were then convened to elicit a range of voices and perspectives that offered equal discursive power to each cohort. The processes encouraged the development of a shared understanding

among participants and the researcher of what constituted a recovery-orientation in mental health services. The method also facilitated reflection on what was working effectively in terms of recovery, alongside a critical appraisal of how values such as equity, social participation, and self-determination were being constructed and preserved through both the organisational talk and the structural arrangements to establish these values in practice.

The chapter also includes a brief discussion of the preliminary findings, (and refers the reader to a more comprehensive discussion in Appendices 7 and 8), that informed the final data analysis strategy and prompted a second review of important literature on institutions, institutional disruption and the significance of translation in transferring ideas, and shaping discourses, across organisational boundaries.

Chapter 6 is the first analysis chapter: *Lost in Translation: Negotiating the discourse of recovery*. This draws on evidence from the data to explore the problematic realisation that within organisations, and societies, some groups have greater control over language, meaning systems and discourse processes. This control seems inevitably accompanied by correspondingly greater opportunities to represent themselves and dominate communicative processes in ways that maintain powerful hierarchies. In particular, it was evident that concepts such as recovery, community and mental illness, were translated variously by significant stakeholders such as clinicians, users of mental health services, community support workers and ordinary citizens.

The second analysis chapter, Chapter 7, is entitled *Encountering the institutions* and examines evidence of the ways in which participants participated in, and resisted, wider social and institutionalised discourses. It examines the extent to which the “common sense” of the social and political world has influenced and penetrated contemporary institutions and organisations. Specifically, it identifies how biomedicine and managerialism have determined legitimate knowledge, definitions of successful service outcomes, and the nature of valid “evidence” in mental health services.

The third analysis chapter, Chapter 8, entitled *Fighting back: Struggles, challenges and innovations*, chronicles how participants and their organisations problematised and challenged institutional influences, the mechanisms of their resistance, and their struggles to remain anchored in strategies for innovation and recovery. It was apparent that, despite their best energy and efforts, these endeavours were idiosyncratic rather than systemic.

In the final discussion chapter, I summarise the analysis of the findings and discuss the practical, theoretical and methodological contributions these make to scholarly understanding of encounters between alternative paradigms and powerfully institutionalised discourses. I also discuss what this means for the expression of an organisation's best intentions. I conclude with the possible implications of this research for further scholarly activity and the challenges that these organisations and the mental health sector still face.

Chapter 2: Background and history

Introduction

The contemporary arrangements of the mental health sector in Aotearoa\New Zealand¹ evolved from a variety of earlier forms that were themselves shaped from the preoccupations and ideological influences of their times. Inevitably, the early historical and socio-cultural influences on what was effectively a colony of the British empire², replicated European ideologies in systems of healthcare generally, and the treatment of the “insane” specifically. Therefore, in this chapter, I tease out the historical threads that, when woven together, illuminate the major political, social and cultural precedents from which contemporary Western mental health services emerged, and the contexts in which they are embedded and enmeshed. In constructing this account, I preview the tensions apparent in the discourses of mental health and mental illness; especially as these have continued to underpin, and influence in varying degrees, the organising processes, practices and discursive formations of contemporary mental health organisations in Aotearoa\New Zealand.

Although the wider social, cultural and political issues for the organisation of mental healthcare will be more fully examined in the literature review chapter, it is important to describe here the social phenomenon that was called “deinstitutionalisation” and examine some important antecedents and consequences for the evolution of community mental health services. It is also

¹ I generally use the term Aotearoa\New Zealand, which acknowledges the parallel, and sometimes shared, histories of Māori as *tangata whenua* (indigenous people) in Aotearoa\New Zealand as well as Pākehā New Zealanders. However, when discussing what was effectively a period of “colonisation” I will use the more common New Zealand as this was a time when Māori and their language were systematically discounted.

² New Zealand was not formally a British colony due to the Treaty of Waitangi that was signed in 1840 between Māori and the British Sovereign. However, most commentators, especially Māori, agree that the country was effectively a colony under successive “Settler” governments from 1852 onwards. Māori clearly suffered all the devastating impacts of colonisation and the state institutions of law, the church, education and systems of healthcare were all imported from Britain.

important to discuss significant policy and legislative changes in Aotearoa\New Zealand that have contributed to the structure and positioning of community NGOs in this country.

In this chapter, therefore, I discuss the historical establishment of mental healthcare organisations in Aotearoa\New Zealand and whether these have been experienced as beneficial or therapeutic by people with lived experience of psychological distress. In other words, have these organisations tended to serve the best interests of individuals and communities or, as many scholars have opined, have they acted primarily as agents of social control and been inherently coercive in acting for the “greater good” of wider society? (Foucault, 1963, 1973; Samson, 1995; Scull, 1979, 1993).

This discussion leads naturally to an exploration of the rise and significance of the service user movement and the role this has played in constructing the concept of recovery as policy in the Aotearoa\New Zealand mental health sector. In this way, I establish some historical anchors to the emerging discourses of recovery and delineate the trends and issues apparent in the current mental health service environment.

The chapter is structured more or less chronologically with the salient features that affect contemporary mental health organisations examined more closely as they arose within the socio-political milieu of each era. I first provide a timeline, in table form (Table 1) of anchors in the chronology of significant events in the history of Aotearoa\New Zealand mental health services. In the discussion that follows, I contextualise the emergence of the community NGOs as a distinct sector and explore the extent to which they have developed an identity and niche within the larger configuration of mental health services in Aotearoa\New Zealand.

A timeline of the organising of mental health services in Aotearoa\New Zealand

Table 1: Chronology of significant events in historical development of mental health services in New Zealand

Key dates	Event	Implications
1840	Pre- asylum era in Aotearoa\New Zealand	Mentally ill behaviour seen as a law and order issue. The “socially undesirable”, including “lunatics” sent to gaol for safekeeping alongside, vagabonds, deserters, prostitutes, delinquents, waifs & strays, drunkards.
1846	<i>Lunatics Ordinance</i> is 1 st Mental Health Act in Aotearoa\New Zealand	New Zealand Law modelled on British legal system emphasising safe custody of the “dangerously insane”
1852	<i>New Zealand Constitution Act</i>	Colonial settler government established a network of provincial lunatic asylums, based on systems of “moral management”. However, lack of public interest eventually returned these to central government control.
1850-1880s	Major legislation introduced in NZ “shaping colonial identities in medicine” (Coleborne, 2001, p372)	1st asylum built at Karori and then Sunnyside Christchurch, Otago and Auckland. Features of early asylums included spacious rural aspects and close interactions with local communities. They generated a degree of self-sufficiency and integrated care through farming, moral influence and quiet routines.
1868	Lunatics Act	Increased public accountability with appointed inspectors and official visitors
1871	First parliamentary inquiry into asylum conditions	Evidence of cruelty and brutality led to removal of administration from lay control and returned to medical.

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1870s	Economic depression in Aotearoa\New Zealand	<p>The halcyon days are over as economic depression leads to overcrowding and general deterioration in conditions.</p> <p>Tensions arise in history of institutional care between responsibilities of medical versus lay personnel. Growing emphasis on medically trained, psychiatric profession claims that mental “illness” a physical disease therefore institutional management increasingly devolved.</p>
1900s to 1950s:	The age of the <i>Psychiatric Hospital</i>	<p>Public recognition of post War trauma (PTSD) meant more attention given to social and environmental factors in diagnoses and treatment.</p> <p>Developments in treatment including “talking therapies” but also experiments in physical treatment such as insulin coma, psycho surgery, ECT etc. Increased potential for cruelty and abuses of power. Offered occupational therapies such as art, music etc. but were always vulnerable to staffing shortages and patients were used as unpaid servants, gardeners, assistants etc. for staff</p>
1950-1970:	The <i>First Wave</i> of deinstitutionalisation	<p>Focus shifted from hospitals e.g. Tokānui, Lake Alice etc. to community but really just geographical re-location rather than shifts in paradigm. Control maintained by psychiatrists using medication, i.e. “chemical straitjacketing” and legislative power.</p> <p>In addition, all the “easy” patients were re-located in a great rush into urban environments, which left the rural hospitals with the “chronic” and “hard” patients.</p>

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1950s	The <i>Psycho-pharmacological revolution</i>	New psychoactive medications credited with initiating first wave of deinstitutionalisation. However, now generally agreed economic and accommodation pressures were really biggest drivers.
1961	New Zealand Joint Commission on Mental Health and Illness leads to <i>Mental Health Act</i> amendment	Simplified committal procedures and opened the door for treatment outside hospital, but mainly because it was cheaper than in-patient stay. However, was also early recognition of the negative effects of institutionalisation
1969	<i>Mental Health Act 1969</i> Aotearoa\New Zealand	Revised outdated words such as “imbecile” & “idiot”. Simplified the committal process but at the expense of human rights. Control of mental hospitals devolved to Hospital boards
1970s	The <i>Second Wave</i> of deinstitutionalisation.	Institutional staff followed employment into newer regimes meaning institutional attitudes and behaviours became re-established Notion of “community” ill-defined and major conceptual confusion and dissonance regarding “community care”. Life in “community” frequently lonely and hostile for those who had been in long-term care in institutions
1972	Government moratorium on institutional expansion in Aotearoa\New Zealand	Focus to reduce number of inpatients and pressure to improve state of care. However, psychiatric hospitals and professionals retained huge amount of institutional power.
1975	<i>Special Report 47</i> , Department of Health	Highlighted systematic neglect and the lack of infrastructure to cope with community care and support. Devolution to other social services and families, who bear burden with no support or financial resources. However, advice that resources for facilities and staff must precede discharge goes unheeded.

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1969-1996	Multiple Public Inquiries in Aotearoa\New Zealand.	<p>More than 70 public inquiries since 1987. Identified overuse of seclusion & restraint, stigma, over-reliance on drug therapy, “Dickensian” facilities, staff shortages and underuse of psycho-social therapies.</p> <p>However, “ritual cleansing” of mental health services (Brunton, 2001) leads to ad hoc, localised, fragmented and uncoordinated policy shifts. Hastily conceived, poorly implemented protocols around ECT, suicide risk, seclusion etc. but no over-arching integrated strategy</p>
1972-73	<i>Royal Commission</i> on Hospital and related services	19 of 43 submissions received from professional interests.
1980s	A growing tide of unrest	<p>Criticism of psychiatric theory and practice include weak construct validity of diagnostic systems and concern about interests of pharmaceutical industry in mental health. This provokes defensive reactions from the medical fraternity.</p> <p>Expose of culture and delivery of mental health services in New Zealand through literature, music, film and arts.</p>
1982	Formal closing of the institutions begins	Lack of community care following formal deinstitutionalisation creates many social problems: Poverty, homelessness, lack of trained support and community resources, negative community reactions.

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1984	4th Labour Government in Aotearoa\New Zealand	Introduces Neo-liberal “Rogernomics ³ ” with a renewed confidence in the market place as only source of social well-being. Key ideologies include: <ul style="list-style-type: none"> • A freely acting individual will best be able to pursue their own best interest • Foster a wider range of choice to consumers because greater competition between providers
1984-1994	Rise of the new non-government organisations	Overall increase in numbers of community non-government organisations. The spectrum is broadened but unevenly distributed (Ministry of Health 1997). Community services include day-care, drop-in, recreational, meaningful activity, vocational etc.
1988	1st Mason Inquiry	A response to public anxiety about the inadequacies of community services being provided in the wake of deinstitutionalization, highlighted by the death of a patient
1988	<i>State Services Act</i>	The health sector is legislated to utilise a generic management structure rather than a professions based hierarchy.
1990-1998:	A period of reforms	The last of the psychiatric hospitals shut down in 1998. Access to hospital is severely restricted, with fewer beds and brief admissions. A “revolving door” syndrome is apparent creating great stress for people and their families especially.

Continued over leaf

³ Refers to then Finance Minister Roger Douglas

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1990-1992	National Mental Health consortium established 1989 and Aotearoa Network of Psychiatric Survivors, 1992	Interest groups coordinate to develop a political voice and particularly mental health service users or “consumers”
1991-1993	Radical restructuring of the New Zealand health system	Promoted health reforms as enhancing freedom of “consumers” to choose between providers. Introduced managerialism and market driven imperatives to health system. Funding of health services separated from provision meaning hospitals are no longer privileged and preferred providers. This increased opportunities for communities, NGOs, iwi etc. to deliver healthcare.
1992	<i>Mental Health (Compulsory Assessment & Treatment) Act</i>	Reformed the 1969 Act, largely on human rights grounds. Increased emphasis on rights of citizenship attempts to balance rights of individual with wider interests of society. Introduces notion of “least restrictive’ environment” and creates separate pathway for judicial review, removing absolute authority of psychiatrists.
1993-1994	<i>Health and Disability Commissioners Act and Code of Consumer Rights</i>	Established the rights of consumers of health services, including mental health consumers to informed choice, appropriate support, to be treated with dignity and respect, and to be treated within their cultural norms.
1994	Publication of <i>Looking Forward: Strategic Directions of the Mental Health Services</i> (Ministry of Health)	Emphasised the need for rapid growth of community mental health services and staff, focused acute services, an anti-stigma campaign, and a large increase in community mental health teams, and new community providers for the NGO sector. But politicians still relying heavily on technical expertise of medical professionals with privileged place in policy and service development as well as resource mobilisation and allocation

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1990-1998:	A period of reforms	The last of the psychiatric hospitals shut down in 1998. Access to hospital is severely restricted, with fewer beds and brief admissions. A “revolving door” syndrome is apparent creating great stress for people and their families especially.
1996	3 rd Mason Inquiry	Findings highlighted "an absence of positive innovative leadership in the mental health sector" and lack of adequate resourcing for community organisations . Major recommendations: Establishment of Mental Health Commission Development of the Blueprint for mental health service provision in Aotearoa\New Zealand Major increase in funding, especially to community sector Mental health money to be ring fenced
1998	Establishment of the Mental Health Commission	“Our vision is for New Zealand to be a place where people with mental illness have personal power, full participation in their communities and access to a fully developed range of recovery-oriented services”
1998	Emergence of Community Support Work models	Service model of Community Support Work developed as practice shifts to community locations and community ideals.
1998	Recovery, a new discourse Publication of <i>Blueprint for Mental Health Services in New Zealand</i> , Mental Health Commission.	“A recovery orientation includes an emphasis on choice, a concept that encompasses support for autonomous action, the requirement that the individual have a range of opportunities from which to choose and full information about those choices” Recovery included as integral for all mental health services i.e. "organisations whose primary function is the provision of care, treatment and support, and education for recovery to people with mental illness, or mental health problems" (p. 111).

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
1998	Publication of <i>Blueprint</i> (cont.).	Recognises large shortfalls in funding and provision of services including community non-government organisations.
1998	<i>Like Minds, Like Mine</i> – Anti- stigma and discrimination media campaign	Raise awareness and intent to increase social acceptance of people with experience of psychological distress, counter myths of dangerousness and risk and plea for social connection rather than segregation. Strong consumer voice being heard, families Māori and PI also
1998	<i>Risk Management Guidelines</i> , Ministry of Health	Seeds of defensive shift back to clinical authority. Recognises risk to individual of illness e.g. risk of violence, unintentional harm to self, quality of life etc. But stops short of acknowledging iatrogenic effects of treatment services and emphasises “risk” to organisation and society.
2000	<i>Health Funding Authority</i> disestablished in favour of District Health Boards	Reinstates hospital based clinical services as both funder and preferred provider of services. Seriously diminishes the role and voice of community non-government organisations in sector development and strategy.
2001	Public apology from New Zealand Government	For those who had received “treatment” in Lake Alice’s adolescent unit that included unmediated electric shock treatment to the genitals and other bizarre and inhumane practices. Dr. Selwyn Meeks is finally de-registered as a psychiatrist in Aotearoa\New Zealand but is not brought back from Australia to stand trial. Apology also acknowledges the appropriation of patients welfare benefits to the tune of millions of dollars over 70s and 80s

Continued over leaf

A timeline of the organising of mental health services in Aotearoa\New Zealand (cont.)

Key dates	Event	Implications
2001	Publication of <i>Recovery Competencies</i> for mental health workers in Aotearoa\New Zealand (Mental Health Commission)	Mental Health Commission publishes criteria for a competent mental health workforce under 10 key areas, with guidelines for assessment of competence.
2003	4 th report of the Mental Health Commission on progress for implementing <i>Blueprint</i> targets	“Despite increased funds, growth has slowed and access to services remains pretty much unchanged”
2004	Publication of <i>Our Lives in 2014</i>	Growing body of New Zealand consumer literature, stories of personal journeys, and visions for future to increase guidance for service development.
2008	Publication of <i>Destination Recovery</i> (Mental Health Advocacy Coalition)	Multi-disciplinary group advocate for role and independence of the non-government organisation sector.
2010	Removal of requirement for at least 1 Mental Health Commissioner to be a person with experience of psychological distress	Further erodes the voice of people with their own experiences of serious psychological distress to influence sector strategy and development.
2012	Mental Health Commission disestablished	Further erosion of any but clinical voice in strategic development of sector.

From Bedlam to Tokaanui⁴: The age of the asylum

Scholars have shown that the historical “truths” about groups of people, their natures and competencies are situated within particular contexts and social orders (Foucault, 1973; Oliver, 1996, 1998; Pearson, 2000; Samson, 1995; Turner, 1995). This was exemplified in 16th and 17th century Europe, for example, when madness came to be seen as the very obverse of reason and rational thought; an implicit loss of what it meant to be human, which, in turn, led to the increasingly inhumane treatment of such unfortunate people. This era saw the emergence of institutions with special responsibility for deviance and lunacy where, previously, care of the insane had been a private affair within families or local communities. The creation of asylums, and the various legislative acts that accompanied their evolution, initiated a long process of segregation and social control that served the powerful interests of the state, church and other social institutions; but which rendered the people incarcerated in these institutions utterly powerless (Foucault, 1973; Luske, 1990; Melling, 1999; Pearson, 2000; Samson, 1995; Scull, 1979; Shorter, 1997; Weeks, 1996). Foucault (1963, 1973) described these origins of state control and social exclusion of vulnerable groups as the “Great Confinement”.

The “Great Confinement”

By the end of the 18th century, the so called Age of Reason in Europe, confinement in places like Bedlam⁵ had further created madness as spectacle; no longer an internal experience but something “other”, to be looked at and contained, to be objectified, externalised and dehumanised. This reduction of madness to an empty negation of reason invoked only scandal or shame and conceded no human value in the experience. Throughout 19th century, in the

⁴ Tokaanui Hospital was a psychiatric facility on the outskirts of Te Awamutu in the Waikato region of Aotearoa\New Zealand. It was the last such hospital in the country to close, and did so finally in 1998.

⁵ “Bedlam” is the colloquial name given to the Royal Hospital of Bethlehem in London, which was the first dedicated facility for the treatment of mental illness. It became notorious as the worst expression of madness as public spectacle and degradation. The term bedlam is now synonymous with uproar and confusion.

Western world, containment and treatment of the insane was controlled by medical, moral and scientific discourses (Foucault, 1963, 1973). This period was also referred to as a “great silence”, where marginalised, segregated groups lost their voice as well as their freedom (Foucault, 1973).

In Aotearoa\New Zealand, the first piece of mental health legislation, the Lunatics Ordinance Act of 1846, enabled care of the insane to be funded from the public purse and be available to all through public hospitals or asylums; although, at this time, none had actually been built. Here, as elsewhere, an increasingly medical monopoly over treatment of the “deviant” meant that the number and size of asylums increased rapidly (Foucault, 1973; Samson, 1995; Scull 1979; Turner, 1995). Between 1854 and 1872, a network of over a dozen provincial, and various other local lunatic asylums was built throughout the country (Coleborne & McKinnon, 2006).

These facilities tended to be located on the outskirts of towns and, when economics allowed, offered a degree of self-sufficiency and a homely, rural lifestyle. An assortment of lay and medical staff provided care and it was anticipated that “cures” would occur as a natural effect of the moral influence and quiet routines (W. Brunton, 2004; Coleborne & Mackinnon, 2006). As elsewhere, these facilities also absorbed paupers, state wards, the intellectually disabled and other social outcasts (W. Brunton, 2004; Coleborne & Mackinnon, 2006).

By the 1870s, however, these halcyon days were over as New Zealand succumbed to economic depression. Conditions in the asylums rapidly deteriorated and in the face of overcrowding and mounting evidence of brutality a governmental inquiry led to the state gaining control over the provinces and administrative care of the asylums was devolved to the medical profession (W. Brunton, 2005; Cheyne, O'Brien, & Belgrave, 2000).

Maintaining medical authority, ostensibly through the pursuit of rational and scientific thought, meant that an extensive range of emotional and mental experiences, social attitudes and behaviours were being pathologised as “madness” and explicated by medical schema (Foucault, 1965; Jureidini, 2012;

Pearson, 2000; Pilgrim & Rogers, 1999). In the first published treatise on psychiatry, for example, Benjamin Rush (1812) identified and medicalised an extensive range of social issues. These included opposition to the American Revolution, atheism, disbelief in the powers of medicine and reactions against the increasing cultural diversity in society. Far from being disparaged, these ideas were the forerunners of social Darwinism and theories of eugenics that dominated psychiatric theory and practice around mental “defectiveness” until the early 20th century.

In Aotearoa\New Zealand, mental fitness was especially important in such a small population; therefore, early identification of delinquency and deficiency, even sexual offending, were considered priorities. Notions of hereditary defect were likewise attributed to criminal behaviour, ethnicity and general impropriety (Samson, 1995; Turner, 1995). This set the scene for a wide net that would eventually become notorious in facilities such as Lake Alice Hospital (W. Brunton, 2004, 2005; Coleborne & McKinnon, 2006; Coleborne, 2012; Marbrook, 2012; Roper & Pearson, 1999).

Constructing madness and the rise of clinical medicine

The epistemological basis of the scientific revolution underpinned the burgeoning authority of psychiatry in Western systems, including Aotearoa\New Zealand. In particular, 19th century positivism (Comte, 1856) and “the scientific method” in medicine had serious consequences for constructions of madness and the treatment of the insane. A preoccupation with “scientific” psychiatry aimed to claim scientific credibility through control over the definitions of mental illness and expansion of the psychiatric diagnostic system. Primarily, scientific positivism insisted that authentic, valid knowledge could only be derived by empirical methods of investigating and measuring the world, including its human subjects. This environment set the scene for increasing experimentation and technological innovation in the advancement of knowledge.

In addition the ascendancy of a single paradigm of health and illness, based on a metaphor of a machine with functioning or dysfunctional parts,

heralded an ever-increasing reliance on physical treatments, including medication, which was transferred wholesale into the treatment of the “mentally ill”. These so-called advances were precursors to the clinical experimentations and physical treatments of the 20th century that included mood altering drugs, psycho surgery and electro-convulsive “shock” treatment (Moncrieff & Crawford, 2001; John Read, Bentall, & Mosher, 2004; D. Rose, Wykes, Leese, Bindman, & Fleischmann, 2003; Scull, 1979).

Experimentation and classification exemplified the triumph of medical rationality over superstition and folly (Conrad & Schneider, 1990) and by the end of the 19th century, access to a scientific body of knowledge gave doctors enormous social prestige and influence (Melling, 1999; Pilgrim & Rogers, 1999). Inevitably, these circumstances created, then as now, considerable controversy about the ethics, validity and usefulness of constructing, and labelling, painful and troubling human experiences as psychiatric disorders (Duncan, Miller & Sparks, 2004; Frances, 2013; Jureidini, 2012; Kirk & Kutchins, 1992, 1994; Kutchins & Kirk, 1997; Pilgrim, 2007; Szasz, 1960).

The history of psychiatry and social control

The professional organisation of medicine in the Western world began about 1800 and in 1847 the American Medical Association was founded to promote the science of medicine. It is necessary to understand these origins in order to appreciate the ingress of these preoccupations into Aotearoa\New Zealand.

Perceptions of the superior effectiveness of scientific medicine led governments to support this unprecedented monopoly with legislation and the professional registration, which limited the rights of practitioners to claim the title of doctor (Conrad & Schneider, 1990; Turner, 1995). In Aotearoa\New Zealand, as elsewhere, professional authority was underscored by the evolution of legislation that began with the Lunatics Ordinance Act, 1846 and carried through to the Mental Health Act, (1969) and the current Mental Health (Compulsory Assessment & Treatment) Act 1992 and its subsequent

amendments. All these statutes embedded professional, psychiatric expertise as the final arbiter in judgements of “unreason”.

Professionalisation and the burgeoning power, prestige and status of biomedicine in Western societies were as much a matter of political manoeuvring as therapeutic expertise and scientific breakthrough (Oliver, 1998; Pilgrim & Rogers, 1999; Samson, 1995; Turner, 1995). Critics noted tensions in the ways that privileged groups such as doctors and psychiatrists became agents of social control and the implications this had for a “socially impoverished underclass” (Scull, 1979, p. 129). Several scholars highlighted the parallel rise of psychiatry and capitalist regimes that regulated social behaviour through ideologically based systems of rules and hierarchical arrangements of power (Althusser, 1971; Foucault, 1973; Oliver, 1998; Pilgrim & Rogers, 1999).

By 1910, medical professionals, throughout the world, had gained a cultural and metaphorical mystique as makers of medical miracles (Conrad & Schneider, 1990) and this created an unprecedented insulation from critiques outside of medicine (Conrad & Schneider, 1990; Freidson, 1970). Psychiatrists by association, and despite the absence of genuine scientific credentials, also entered into this era of “unparalleled professional dominance” (Conrad & Schneider, 1990, p. 145) and were functionally autonomous as a professional group. Notwithstanding their perceived “Cinderella” status within the larger medical fraternity (Bond, 1915), psychiatrists were eager to extend their reach. In Aotearoa\New Zealand, as elsewhere, they accepted substantial administrative authority from the state to segregate, contain and control the perceived threat of socially marginalised groups (Jermier, 1998; Oliver, 1998; Samson, 1995; Scull, 1979; Szasz, 1960, 1974; Turner, 1995; U’Ren, 1997). Over time, these came to include the unwanted, the poor and the disabled (W. Brunton, 2004, 2005; Coleborne & McKinnon, 2006; Dalley & Tennant, 2004; Joseph & Kearns, 1996, 1999).

Eager to improve their professional credibility and, emboldened by their relative isolation in self-sufficient, rural facilities, psychiatrists indulged in a wide range of experimentations under the guise of treatment. These are now widely

recognised to have been as much punitive as therapeutic (O'Brien & Golding, 2003; O'Brien et al., 2009; Pescosolido, Wright, & Sullivan, 1999). These included various coercive techniques, chemical and social "technologies" such as isolation, deep-sleep and insulin "therapies" to control behaviour. Eventually, their growing administrative power alongside the increasing dominance of biomedical explanations of "mental illness" meant the asylums ceded to hospital type settings. In New Zealand, this transition occurred in 1911, by merely renaming the Porirua asylum, Porirua Hospital.

1900s to 1950s: The age of the psychiatric hospital

The long history of *ad hoc* experimentation in psychiatry was the legacy of the functional autonomy of psychiatric medicine that began in the asylums of the late 18th century. This occurred despite the science of medicine being based on traditions and discourses that proved unreliable and altered markedly over time (Foucault, 1963, 1973). Nevertheless, the psychiatric hospitals were dominated by medical professionals and characterised by experimental treatments. Segregated from other social influences this heralded an era of unbridled, systemic power where a range of cruelties and brutalities went unchecked (W. Brunton, 2005; Coleborne & McKinnon, 2006; Mason, 1988).

An age of experimentation

In assuming the mantle of objective, empirical science psychiatrists freely undertook a range of medical and technological experiments; nearly all of which have been subsequently discredited as ineffectual, harmful and frequently macabre (Drake et al., 2003; Melling, 1999; Samson, 1995; Scull, 1994). The phenomenon of shell-shock, first seen during World War I, further encouraged psychiatric experimentation as army doctors were pressured to return soldiers as fit for active service (Rosenberg & Mueser, 2008). However, post-traumatic stress disorder, as it would come to be recognised, was so endemic it became impossible to explain away as personal cowardice (Melling, 1999; Miller & N. Rose, 1988; Pilgrim, 2002). In fact, the experiences of both World Wars exposed widespread and unprecedented experiences of psychological trauma that shifted

lay perspectives towards an understanding of environmental and social factors in the origins of serious distress (Rosenberg & Mueser, 2008; Samson, 1995).

Nevertheless, experimentation and psychiatric research continued in the 1920s with the development of a range of “shock” treatments. These included the inducing of comas or convulsions with agents such as insulin and Metrazol as well as electro-convulsive shock, psychosurgery and infection with the malaria virus (Braslow, 1997; Forman, 1975; Grob, 2004; Melling, 1999; Moncrieff & Crawford, 2001; D. Rose et al., 2003). In New Zealand, effectively a colonial outpost for such practices, Janet Frame, one of the country’s most renowned authors, documented her experience of such treatments in short stories, novels and autobiographical writings (Frame, 1960, 1982, 1985). Frame famously escaped a scheduled lobotomy solely because her first book of short stories was accepted for publication, which impressed her doctor enough to cancel the surgery (Frame, 1960, 1984).

Subsequent scholarship, notably renowned Māori psychiatrist Mason Durie (1985) and psychiatric survivors such as Mary O’Hagan (1991) would add the voices of Māori and other people with lived experience of psychological distress to the clamour for change. However, despite attracting widespread critical press in the 1960s and 1970s many of these “treatments” were not phased out for decades: nor was the iatrogenic harm or negative impacts of such practices acknowledged (Deegan, 1990; Frame, 1960, 1982, 1985; Moncrieff & Crawford, 2001; Scull, 1979).

Paradoxically, many of the psychiatric hospitals in New Zealand offered a sense of community, absent in wider society; they frequently provided people with a sense of belonging, relationship and a place in the world (W. Brunton, 2001; Coleborne & Mackinnon, 2006; Joseph & Kearns, 1999; Scull, 1979, 1984; Yip, 2000). They aimed to be self-sufficient environments with farms and other cottage industries that employed patients as unpaid labour (W. Brunton, 2004; Coleborne & Mackinnon, 2006; Fenton & Te Koutua, 2000; Joseph & Kearns, 1999; Leonard, 1999). Ideas of moral therapy and the benefits of living a good, quiet life were evident in places and were precursors to recovery in their

awareness of the humanitarian aspects of care (Coleborne & McKinnon, 2006; John Read & Dillon, 2013; Scull, 1993). However, these approaches never truly prevailed in the way that bio-medicine did (Pilgrim & Rogers, 1999; Pilgrim, Kinderman, & Tai, 2008; John Read et al., 2004; Szasz, 1960; Thomas et al., 2005).

Social and psychoanalytical approaches to mental health have been widely assumed to rise in importance in the earlier part of the 20th century (Braslow, 1997; Grob, 1983; Kendell & Zealley, 1988). However, as Moncrieff and Crawford (2001) demonstrated in their comprehensive review of the *British Journal of Psychiatry* in the 20th century, physical treatments such as electroconvulsive therapy (ECT) and insulin coma therapy, as well as a large array of sedative drugs, were always the mainstay of treatment regimens (Kecmanovic & Hadzi-Pavlovic, 2010; Moncrieff & Crawford, 2001). Their findings corresponded with other evidence that treatment remained focused on physical procedures and psycho-active drugs rather than talking-based, or psychoanalytic, therapeutic approaches (Braslow, 1997; Grob, 1983; Moncrieff, 2008). In fact, during the 1950s, despite a slowdown in the scientific “triumphs” of medicine, the pharmaceutical industry dramatically increased production of an extremely profitable, plethora of psychiatric medications (Chalmers, 2001; Healy, 2002; Thomas et al., 2005; Whitaker, 2002).

Despite their best endeavours, psychiatry remained alienated from the general medical professions in the Western world, as a non-scientific embarrassment (Bond, 1915; Turner, 1995). There was still no biological evidence for “mental illness” and a lack of effective medical remedies. This stasis encouraged psychiatrists to expand their administrative reach far beyond the boundaries of their technical competence into social management (Conrad & Schneider, 1990; Foucault, 1973; N. Rose, 2006; Samson, 1995).

The desire for increased professional legitimacy, alongside a new chemical arsenal of mind and mood altering drugs, meant that psychiatrists worldwide lobbied successfully for increasing medical intervention in social issues such as public health and welfare (Barker & Buchanan-Barker, 2012; Moncrieff, 2007; Pilgrim & Rogers, 1999; N. Rose, 2006; Turner, 1995). The

general diminution of the role of human agency (Miller & N. Rose, 1988; Weber, 1946) and the valorisation of professional expertise led to an increase in the “bureaucratic regulation of the whole of social life” (Samson, 1995b, p. 63) and facilitated the medicalisation of Western societies.

The medicalisation of society and social Darwinism

Foucault (1963), among other scholars (Pilgrim & Rogers, 1999; John Read et al., 2004; Turner, 1995), was concerned that the clinical gaze not only conferred unprecedented authority for social management on medical professionals but also afforded them considerable social power in defining the “reality” of deviance and disorder. Andrew Scull (1979, 1993a) characterised this period as a kind of professional imperialism preoccupied with defining emotional and psychological events, whether individual or social, as medical phenomena rather than human experiences. This era, unsurprisingly, extensively broadened the definitions of madness and medicalised a wide range of social issues and personality characteristics (Pilgrim & Rogers, 1994; Samson, 1995; Scull, 1979, 1993). Homosexuality, for example, was only finally removed from classification as a psychiatric disorder in 1973 (Spitzer, 1999).

Throughout this period, in psychiatric hospitals throughout the Western world including Aotearoa\New Zealand, state control of the “deviant” became extreme (W. Brunton, 2001, 2005; Coleborne, 2012; Joseph & Kearns, 1999; Marbrook, 2012; Rose N., 2006). Legislation provided psychiatrists with both the right and the responsibility to detain patients and emphasised coercive, social control rather than therapeutic care (Grob, 1991, 1994; Melling, 1999; Porter, 1991; Rose N., 1996, 1998; Scull, 1979, 1993). This meant that the power of psychiatry became more a set of occupational privileges, reliant on the arrangements of political, economic and cultural power, rather than an adherence to some trans-historical and invariant properties of biomedical science (Foucault, 1963, 1973; Jureidini, 2012; Leclercq-Vandelannoitte, 2011; Samson, 1995; N. Rose, 2006).

Coercion was a natural consequence of the social Darwinism that dominated scientific thought in the first decades of the 20th century. This aspect of modernism not only separated the “deviant” from the “normal” but constructed patients as worthless, powerless, dangerous and to be removed from the gaze of normal society (Foucault, 1963, 1973; Grob, 1991, 1994; Melling, 1999; O’Brien & Golding, 2003; Rudge & Morse, 2001; Scull, 1997). Administrative power within cloistered environments enabled psychiatrists to enforce compliance and regulate the behaviour of the wayward and abnormal, including wards of the state, people with intellectual disabilities and others (W. Brunton, 2004; Coleborne, 2012; Scull, 1979, 1994).

Increasingly, the social value and ethic of paid work created an obligation for able-bodied people to participate productively in the economy. This meant that health, too, had economic value, and a lack of it meant becoming a de-valued or “in-valid” person in society (Grob, 1991, 1994; Harter, Scott, Novak, Leeman, & Morris, 2006; Oliver, 1998; U’Ren, 1997). The “mad”, like other vulnerable groups, then became further marginalised as *unproductive*, thereby justifying their alienation from community life. They had no status as citizens; the logical repercussion of which was the systemic loss of human rights and civil protections (O’Hagan, 1994). Thus, they were truly *dis-abled* and set apart, geographically as well as socially, from the able bodied, “contributing” members of their communities (Harter et al., 2006; Oliver, M., 1998; Scull, 1979). Social technologies, such as hierarchical surveillance in its various forms (Bentham, 1791; Foucault, 1963, 1973, 1977) further served to normalise the depersonalisation, stigma and systematic removal of personal power experienced by people subject to state intervention (Deegan, 1990; Fisher, 2000; O’Hagan, 1991, 1994; Scull, 1979, 1993).

Patients, or psychiatric survivors as they came to be called (Adame, 2006; Goslyn, 1997; O’Hagan, 1991), increasingly, and vigorously, resisted coercive and compulsory treatments. They experienced them as harmful, painful, frightening and ultimately ineffectual in reducing symptoms and distress (Deegan, 1990; D. Rose et al., 2003; Samson, 1995; Scull, 1994). Stories from this era, the accounts

of staff, administrators and eventually patients exposed frequent brutality and cruelty, as did the scandals that initiated public inquiries such as those into Lake Alice Hospital in 1976, 1977 and 2001 (W. Brunton, 2004, 2005; Coleborne, 2012; Marbrook, 2012; Mason, 1988, 1996).

English psychiatrist Russell Barton (1959, 1972) was the first to acknowledge publicly the negative impacts of long stay confinements when he described “institutionalisation” as iatrogenic illness in 1959. Despite being largely ignored by professional scholars, this signalled a growing social awareness of the damage caused by some treatments and other issues surrounding coercive practices in psychiatric hospitals. This was one of several factors that contributed to a decline in the material and ideological dominance of the “institution” (Anthony, 1993; Deegan, 1990; Fisher, 2000; O’Hagan, 1991, 1994; Pearson, 2004). Psychiatrists in Aotearoa\New Zealand, as elsewhere, were realising that being excluded, in facilities located outside populated areas, applied equally to the powerful and powerless and they, too, were stigmatised, isolated and disconnected from the wider medical fraternity (Pilgrim & Rogers, 1999, 2005b; Turner, 1995). Eventually, these pressures, alongside economic imperatives, staff shortages and overcrowding led to the beginning of the social phenomenon known as “deinstitutionalisation” (W. Brunton, 2001, 2004; Joseph & Kearns, 1996, 1999; Leibrich, 1988, 1998; Pilgrim & Roger, 1999; Turner, 1995).

1950-1970: The social phenomenon of “deinstitutionalisation” and being out in the “community”

“Deinstitutionalisation” in New Zealand followed global trends and occurred in two broad waves, the first occurring in the 1950s. The development of new psychotropic medications was widely credited as the catalyst for this, but most commentators now accept that economic and other pressures had already initiated the movement away from the institution based approach (Grob, 1994; Healy, 2002; Kirk & Kutchins, 1992; Moncrieff, Cohen, & Porter, 2003; Samson, 1995; Scull, 1979). These pressures included social and professional disquiet at conditions within the psychiatric hospitals.

Concurrently, assumptions of the benevolence of institutional care were being thoroughly challenged, particularly in new sociological critiques of medicine and psychiatry (Dalley, 1988; Grob, 1991, 1995; Pilgrim & Rogers, 1999, 2005a, 2005b). Significant shifts in thinking, from the purely biomedical to social theories of the origins of mental illness, became apparent, (Laing, 1960; Samson, 1995); and it was increasingly recognised that psychological states are complex, involving subjective experience and meanings, personal needs and priorities, as well as environmental and socio-cultural circumstances (Pilgrim et al., 2008; Rappaport, 1987; Treacher & Baruch, 1981).

Globally, the development of a sociology of medicine turned a critical gaze on professional orthodoxy that constructed understandings of illness as a purely individual, pathological process (Bracken & Thomas, 2010; Miller & N. Rose, 1988; Pilgrim & Rogers, 1999, 2005a, 2005b; Scheff, 1999; Treacher & Baruch, 1981; Waitzkin, 1989). The beginnings of the *anti*-psychiatry movement were evident within psychiatry, initially through the works of Thomas Szasz (1960) and R.D. Laing (1960), who challenged the very basis of the biomedical construction of mental illness (Treacher & Baruch, 1981).

Labelling theory also gained traction, articulated by Thomas Scheff (1974, 1999) among others, which posited that behaviour characterised as deviant causes social outrage merely because it is fundamentally non-conformist (Pilgrim & Rogers, 1999; Sayce, 2000). According to these protagonists, the “powerless position and low social status of psychiatric patients rendered them both unimportant and invisible” (Pilgrim & Rogers, 1999, p. 125).

However, the reality of deinstitutionalisation as policy in Western nations was fraught and based on the premise that care and treatment could be standardised and psychiatric authority maintained (Grob, 1995). In Aotearoa\New Zealand, provisions of the various Mental Health Acts up until the major reforms of 1992 (Ministry of Health, 1969, 1992), meant that people could be compulsorily treated in the community and non-compliance could invoke immediate recall back into an institutional facility (O’Brien et al., 2009). The real power of the “new”, powerfully psychoactive medications, therefore, was social

coercion rather than therapeutic aid. They reduced the need for costly, physical containment and enforced “compliance” beyond the hospital gates (Cohen, 1997; Healy, 2002; Moncrieff, 2007, 2008; Moncrieff et al., 2003). They did little to improve the quality of community life for patients (Cohen, 1997; Leibrich, 1988; Pilgrim & Rogers, 1999; Samson, 1995; Scull, 1977, 1979; Turner, 1995).

In Aotearoa\New Zealand, too, widespread assumptions about a new era of community care did little to shift the preoccupations of psychiatry in mental health services (W. Brunton, 2001; Johns, 2010; Joseph & Kearns, 1999; Leibrich, 1988; Leonard, 1999; Mason, 1988, 1996; Warren, 1997). Instead, mental health services were engaged in reconstructing “the institution” outside the hospital environment without posing any substantial challenge to the power, authority or treatment modalities of the biomedical model (Curtis & Hodge, 1994; Leibrich, 1988; Leonard, 1999; S. Rose & Black, 1985; Sullivan, 1992; Warren, 1997). Therefore, the first wave of deinstitutionalisation comprised merely a geographic relocation of people, and services, into urban neighbourhoods rather than engagement with a community “out there” that cared; a psychological community of social networks and relationships, resources and opportunities as was widely assumed (Dalley, 1988; Durie, 1985, 1999; Grob, 1991, 1995; Joseph & Kearns, 1999; Leibrich, 1988; Leonard, 1999).

Psychiatry and the “new” medications in community care

Discharging people from the large institutions was not noticeably hastened by the medication “miracles” of the 1950s although this continued to be a convenient assumption for psychiatrists and a burgeoning pharmaceutical industry (Leff, 1997; Melling, 1999; Pilgrim & Rogers, 1999; Samson, 1995; Whitaker, 2004). Psychiatrists, also unbound from the asylums and who were actively participating in discourses of science that affirmed the physical origins of “mental illness”, rationalised the emphasis on physical treatments and the chemical control of behaviours (Miller & N. Rose, 1988; Pilgrim, 2007; Pilgrim & Bentall, 1999; Pilgrim & Rogers, 1994, 1999; Szasz, 1974). But medication was more “chemical straitjacket” than “magic bullet”, and the so-called new

medications proved to be a poisoned chalice (Breggin, 1993; Cohen, 1997; Healy, 2002; Hubble et al., 1999; Moncrieff, 2008; Scull, 1994; Whitaker, 2004).

Psychiatrists and legislators of this time were primarily concerned with the effectiveness of drugs in terms of symptom reduction and behaviour control, and they continued to resist evidence of the seriously undesirable, permanent and disabling side-effects of medications (Breggin, 1993; P. Brown & Funk, 1986; Cohen, 1997; Healy, 2002; Moncrieff et al., 2003; Moncrieff, 2007, 2008; Whitaker, 2004). Stephen Finn and colleagues noted that “psychiatrists saw side-effects as significantly less bothersome than symptoms when considering costs to society” (Finn et al, 1990, p. 843). Prescription rates, therefore, continued to grow in both dose and frequency (P. Brown & Funk, 1986; Deegan, 1990) and commentators were increasingly concerned that the need to be seen as scientific was closely associated with a mutually beneficial alliance between psychiatry and the pharmaceutical industry (Chalmers, 2001; Double, 2002, 2006; Healy, 2002; Jureidini, 2012; Moncrieff et al., 2003; N. Rose, 2003; Whitaker, 2004). David Pilgrim and Anne Rogers (1999) noted that an “over-reliance on drug treatment [was] inextricably linked to a professional strategy of collective upward mobility on the part of psychiatrists” (p. 125). In other words, patient welfare was systematically disregarded in favour of the political aspirations of psychiatrists (Baruch & Treacher, 1978; P. Brown & Funk, 1986; Pilgrim & Rogers, 1999, 2009; N. Rose, 1996; Treacher & Baruch, 1981).

Managing the effects of medications, and their serious and long term side-effects, meant true participation in the community, for example through employment and education, was not a realistic aspiration for many people, stigma and discrimination aside (Carling, 1995; Chamberlin, 1988; Joseph & Kearns, 1999; Keyes, 2002; Leff, 1997; Morgan, C., Burns, Fitzpatrick, Pinfold, & Priebe, 2007; Sayce, 2000; Sullivan, 1992). Julie Leibrich, a founding commissioner of the newly formed Mental Health Commission, was to comment that the shuffling gaits and glazed eyes of heavily medicated people in the community merely reinforced popular stereotypes, and became a self-fulfilling

prophecy in terms of their inability to reclaim worthwhile and valued lives (Leibrich, 1998).

Medical sociologists and social psychiatrists, particularly, were the foremost critics of biomedical psychiatry and the dominance of medical values and professional needs (Kecmanovic & Hadzi-Pavlovic, 2010; Pilgrim & Rogers, 2005b; Saleeby, 2002; Scheff, 1999; Turner, 1995). They were concerned to understand the subjective experiences alongside other external and environmental influences on a person's behaviour and emotional state; it was from this alliance that the bio-psycho-social model was developed (Abbott & Wallace, 1990; Pilgrim & Rogers, 2005a, 2005b; John Read, 2005; Pilgrim et al., 2008).

The bio-psycho-social model

The bio-psycho social model of mental healthcare arose in the 1950s and has probably been the most widely recognised response, in Aotearoa\New Zealand, as elsewhere, to biomedical reductionism. The model attempted to downplay the role of diagnosis, instead seeking to investigate the relationships between psychological distress and social contexts (Cook & Wright, 1995; Goldberg & Huxley, 1992; Pilgrim & Rogers, 2005). It appealed to mainstream clinical professionals because it maintained confidence in positivist notions of causality and the reification of mental illness (John Read, 2005; Szasz, 1960, 1974; Turner, 1995). However, it also drew criticism from opponents of psychiatric theory and practice because it did not reject diagnosis entirely (Barker, 2003; Melling, 1999; Pilgrim, 2002; John Read. 2005; Szasz, 1960, 1974). In the end, the model was weakened by a seemingly irreconcilable split between medical sociologists and biomedical professionals (Clare, 1980; Conrad & Schneider, 1990; Fee, 1990; Pilgrim & Rogers, 2005a, 2005b). The interdisciplinary void this engendered effectively subsumed the legitimacy of scholarship about the socio-cultural aspects of serious psychological distress for several decades (Pilgrim & Rogers, 2005b).

Despite this, the general public believed that the social phenomenon of deinstitutionalisation was primarily ideological and focussed on human and civil rights. According to Michael Oliver (1998), those who championed the move from the “institutions” to the “community”, naively believed that this move towards “normalisation” granted patients greater freedoms (H. Brown & Smith, 1992; Wolfensberger, 1980). In reality, mental healthcare reforms remained driven largely by professional interests (Moncrieff & Crawford, 2001), while legislation and compulsory treatment orders ensured that clinical professionals continued to exert control over patients outside the hospital walls.

1970s: The second wave of deinstitutionalisation

The public perception in New Zealand was that community care was fundamentally different from institutional care; that treatments had become more humane and people were now able to live more ordinary lives “in community” (Carling, 1995; Drake et al., 2003; Sullivan, 1994; Susser, Conover, & Struening, 1990; Turner, 1995; Warriner, 1997). However, deinstitutionalisation, as a social process, did not equate to community care (W. Brunton, 2001; Caird, 2001; Leff, 1997) and the second wave of deinstitutionalisation was driven by the promise of fiscal efficiencies and was, again, merely a physical relocation of people into neighbourhood settings (W. Brunton, 2005; Joseph & Kearns, 1996, 1998; Leonard, 1999; Mason, 1988, 1996; Prior, 1993). This meant that people with diagnoses of mental illnesses were typically *in* the community but not *of* it (Durie, 1985, 1994; Grob, 1995; Leonard, 1999; Mason, 1996; O'Hagan, 1991).

Community “care”

In practical terms community care was just a euphemism for community neglect, and New Zealand communities were unprepared for the uncomfortable and inconvenient eyesores of poverty, homelessness, alcoholism and untreated emotional distress that resulted (Leibrich, 1988, 1998; Ministry of Health, 2003; Sayce, 2000). The critical distinction between care *in* the community and care *by* the community meant that, for most people leaving the institutions, being in the community meant joining the transient underclass of marginalised, impoverished

people in society (Durie, 1985, 1994; O'Hagan, 1999; Warren, 1997). In addition, assumptions of a community "out there" that cared also implied the existence of social arrangements and relationships where people would willingly be responsible for each other (Durie, 1994, 1999; Grob, 1991, 1995; Leff, 1997; Mason, 1988). Unfortunately, and more commonly, social supports tended to shrink and relationships fall away (Koegel, Burnam, & Baumohl, 1996).

Similarly, the presumption that funding would be transferred from the institutions into "the community" proved to be misplaced, and resources did not follow patients into communities as promised (Joseph & Kearns, 1999; Mason, 1996; Warren, 1997; Warriner, 2001). Equity and human rights issues were similarly compromised by economic priorities in the deinstitutionalisation agenda, amidst unrealistic expectations of, comparatively, non-existent community services (W. Brunton, 2001; Durie, 1994; Prior, 1993). As one commentator wryly explained, a "good way of saving money on community care is, of course, to provide very little of it" (Leonard, 1999, p. 134) and this appeared to be the policy strategy in New Zealand as elsewhere (Leonard, 1997; Mason, 1988, 1996; Prior, 1993). These factors combined to create an illusion of social integration where, in fact, people's inability to adapt to community expectations led to social exclusion, stigma and hopelessness (Lapsley & Yee, 2004; Sayce, 2000, 2001; Vaughan & Hansen, 2004).

The practical responsibility for "community care" devolved, by default, to existing charitable trusts that were already providing generic social services (W. Brunton, 2001; Caird, 2001; Joseph & Kearns, 1999). At this time, they were ill-prepared to manage the support needs of people who had few skills for coping in an alien environment and who exhibited bewildering behaviours and symptoms (Carling & Allott, 1999; Leibrich, 1988; Mental Health Commission, 1997; Sayce, 2000). Critics highlighted the lack of even a weak policy framework and a fragmented, *ad hoc* approach to the development of community services (W. Brunton, 2001; Joseph & Kearns, 1996; Wade, 1999; Warriner, 2001). Facilities were underdeveloped, resources grossly inadequate and the community organisations lacked the skills, vision and strategic direction to implement a

systematic plan for meeting the broad needs of people to live ordinary lives in their community (Mason 1996; Warriner, 2001).

In addition, biomedical psychiatry and Western worldviews effectively colonised New Zealand mental health services (Coleborne & Mackinnon, 2006; Durie, 1999, 2001, 2009; Dyall, 1997). This meant that a disproportionate amount of the impacts of deinstitutionalisation policy fell on Māori, for whom containment in the institutions had more completely disenfranchised them from the support of whānau⁶, hapū⁷ and community (Durie, 1994, 2001). Cultural conceptualisations of mental health, psychological distress, and appropriate forms of support and treatment were totally ignored (Fenton & Te Koutua, 2000; Lapsley & Nikora, 2002; Nikora, 1993). As they were discharged from the large psychiatric facilities Māori, more than any other group, were isolated and stigmatised. Statistically Māori and Pacific Island men were shown to be more likely to have traumatic, police-involved admissions into in-patient services; they also received higher doses of powerful medications, in greater quantities and with greater frequency (Abas et al., 2003; Wheeler, Robinson, & Robinson, 2005).

Unsurprisingly, these circumstances provoked a long period of community backlash, where deinstitutionalisation was decried as an ideological failure and a social experiment gone wrong (W. Brunton, 2001, 2004; Grob, 1995; Leibrich, 1988; Mason, 1988, 1996).

1980s: The growing tide of unrest

The last psychiatric hospital in New Zealand did not close its doors until 1998 and in-patient treatment services continued to receive over 80% of mental health funding through the 1980s and into the 1990s (W. Brunton, 2001; Hall & Joseph, 1988; Johns, 2010; Joseph et al., 2009). But by the time the hospitals finally closed, mental healthcare had been out of the public consciousness for so

⁶ Whānau is the Māori term for family and includes notions of extended family

⁷ Hapu is a Māori term that refers to a sub-tribal group that reside within the same geographical region. Whānau, hapu, iwi are key features of Māori social organisation.

long, and the territory so exclusively claimed by the medical profession, that there was a critical ignorance about the nature, origins and consequences of serious mental and emotional states. There was also a tragic lack of understanding that many of the people who had suffered long-term stays in psychiatric hospitals were exhibiting the appearance and behaviours of institutionalisation (Scull, 1993) and the side effects of medication rather than symptoms of mental illness (Anthony, 2006; Deegan, 1990; Oaks, 2006; N. Rose et al., 2006). Lay understandings of institutions were similarly vague and the general public assumed that “institutionalisation” was a thing of the past and referred merely to the closure of large rural facilities (Johns, 2010; Prior, 1993; Warriner, 2010). In fact, deinstitutionalisation was a slow process.

In addition, ambiguous constructions of “community” contributed to the backlash commonly referred to as the “NIMBY” (Not in My Backyard) principle (Fakhoury & Priebe, 2002; Joseph & Kearns, 1996; Mental Health Commission, 1997; Sayce, 2000). Although this phenomenon reflected genuine concerns about the capacity of the community to accommodate new members, underlying the rejection was the misperception that the *problem* was the people with mental illness rather than a serious, systemic and political issue. It was not until Judge Ken Mason’s first public inquiry in 1988 that the problems of desperately inadequate resourcing and capacity were publicly identified as the primary issues of community resistance to community care (Mason, 1988).

Nevertheless the community unrest was countered by a burgeoning activism among “psychiatric survivors” (Goslyn, 1998), in conjunction with similar social and human rights movements throughout the world. In Aotearoa\New Zealand, the Aotearoa Network of Psychiatric Survivors was formed in the 1980s in an attempt to develop a collective, political identity alongside other social movements such as Gay Pride, Feminism and various Māori, as well as other indigenous peoples, lobby groups (Cohen, 1985; O’Hagan, 1991; Warner, 2004). This group endeavoured to enable people with negative experiences of the institutions to grow their political voice and reclaim the rights of citizenship as well as wider civil protections (Everett, 1994; Oaks, 2006).

Social activism and the psychiatric survivor movement

The Aotearoa Network of Psychiatric Survivors (ANOPS) emerged as a new subject position (Goslyn, 1997; Maguire & Hardy, 2009; Mumby, 2005; O'Hagan, 1991) in the discourses of mental health treatment and care in this country. They, and similar groups, also facilitated the gathering of personal accounts of the experiences of distress, as well as stories of the trauma endured as a direct result of treatment services themselves (Anthony, 1993; Deegan, 1990; O'Hagan, 1994; Leibrich, 2000). This social activism was reinforced in large part through fictionalised and non-fictional accounts of life inside the mental hospitals from perspectives of inmates⁸ (W. Brunton, 2005; Frame, 1982a, 1982b, 1984, 1985; Forman, 1975; Kesity, 1962; Nairn, 1999; Scull, 1993). Alongside personal narratives and sympathetic accounts, newsworthy incidents, revelations and scandals made some of these issues politically sensitive and raised a level of public disquiet (W. Brunton, 2005; Dalley & Tennant, 2004; Mason, 1988).

Advocates demanded that society recognise the oppression and marginalisation of psychiatric patients and called for the systemic redistribution of social and political power as well as individual rights to self-determination (Fisher, 1994a; Lord & Dufort, 1996; Jacob Read, 2003b; S. Rose, 2000). They highlighted stigma, discrimination and the disabling impacts of many social environments; as well as the systemic structures and policies that presented barriers to equitable social participation for people with diagnoses of mental illness (Kendrick, 1997; Lapsley & Yee, 2004; Mental Health Commission, 1997; Rappaport, 1995; Sayce, 2000). Disability advocate Michael Oliver (1998) described the challenges as:

[Moving] beyond the personal limitations that impaired individuals may face, to social restrictions imposed by an

⁸ For example, in this country Janet Frame's autobiographical novel 'Owls Do Cry' (1960) and subsequent non-fictional trilogy 'An Angel at my Table' (1982, 1984, 1985) were the first accounts to enter the public domain. Elsewhere populist movies such as 'One Flew Over the Cuckoo's Nest' (Kesity, 1962; Forman, 1975) had exposed cracks in the previously seamless narrative of 'us' and 'them'

unthinking society. Disability is understood as a social and political issue rather than a medical one, and this leads to critical questioning of medical interventions: attempts to cure impairments or to restore "normal" bodily functioning (p. 1446).

For most psychiatric survivor/consumer⁹ activists, there was, inevitably, a political as well as personal need to challenge the social contexts in which the process of alienation occurred (Chamberlin, 1988, 1998; May, 2001; Rappaport, 1987; N. Rose, 1996). Over time, these efforts included media campaigns such as *Like Minds, Like Mine* (Ackroyd & Wyllie, 2002; Lapsley & Yee, 2004; Perkins & Repper, 2013; Vaughan & Hansen, 2004) and an on-line presence through websites, forums, blogs and support groups¹⁰. All these initiatives focussed on managing the damaging impacts of prejudice, stigma and low expectations of people who experienced serious psychological distress, in contrast to conventional psychiatry's efforts to determine the causes of perceived deficiency or illness.

Simultaneously, Māoridom was beginning to develop robust challenges to the ways that Pākehā (European) New Zealanders were interpreting their experiences, and had embedded institutional racism in education, health and public services (Barnett & Barnes, 2010; Durie, 1985; Ministry Advisory Committee, 1988). They had begun to develop their own models of mental healthcare, led by notable Māori scholar and psychiatrist Mason Durie (Durie, 1994, 2009; Dyllal, 1997; Ramsden, 1997; Ministerial Advisory Committee, 1988; Te Ngaru Learning Systems, 2002).

However, despite these contributions to a growing body of alternative thought in mental healthcare, the orthodox drive in biomedicine did not slow,

⁹ "Consumer" became a term of self-identification for people with lived experience of psychological distress in the early 1990s. This will be discussed further in the section *New Acts: Changes in NZ policy and legislation*, and the evolution of the language of identification is discussed in some depth in *The Problematic of Voice* section of the literature review.

¹⁰ For example, Openmind.org, Scottish Recovery Network, thelowdown.co.nz among many others

and was in fact spurred on by vociferous public approbation of technological advances in physical medicine and the funding resources these attracted (Bennett, 1991; Melling, 1999; Moncrieff & Crawford, 2001; Pilgrim, 2002, 2007; Pilgrim & Rogers, 1994, 1999; Prior, 1993; Scull, 1994). Critics, including “psychiatric survivors”, were deeply concerned that the situated, subjective and communal understandings of the experiences of serious distress were made invisible and the voices of marginalised peoples unheard (Adame, 2006; Broadfoot & Munshi, 2007a, 2007b; Fisher, 2000; Foucault, 1963, 1973; Weick, 2000). There was also concern building within psychiatry.

The “myth” of mental illness

Psychiatrist Thomas Szasz (1960) believed there was a fundamental error in reasoning about mental illness and he argued that the notion had outlived any usefulness it might have had and was functioning merely as a convenient “myth” (Szasz, 1960, 1974). While he, and others, did not minimise the social and psychological distress that many people experienced, they were deeply concerned about the consequences of the biomedical explanatory models attributed to them (Bracken & Thomas, 2010; Breggin, 1993; Laing, 1960; Scheff, 1974; U’Ren, 1997).

Orthodox psychiatry, on the other hand, continued to define emotional distress in terms of individual, disordered experience. Social and cultural factors were, at best, treated as secondary and not generally taken into account. This intransigence was partly due to most psychiatric encounters still occurring in hospitals and clinical services (W. Brunton, 2001, 2004; Bracken & Thomas, 1998, 1999; Duncan et al., 2004; Joseph & Kearns, 1996). But, gradually and haltingly, the community NGOs began to understand the complex challenges of the situation that had arbitrarily devolved to them. They also began to recognise the many shortfalls in the resources available to them.

As the 1980s came to an end, there was a general unease and foment of unrest from many quarters within New Zealand following several scandals in mental health services (Boston, Dalziel, & John, 1999; W. Brunton, 2001, 2004,

2005). It was in this climate that the first of three major inquiries was commissioned by the Government and led by Judge Ken Mason (1988). His subsequent report was deeply critical of conditions in the psychiatric hospitals and the configuration of mental health services. Despite his findings, the social and political power of stakeholders, for whom the control and management of large public psychiatric hospitals remained a vested interest (Ashton, 1999; W. Brunton, 2005; Joseph & Kearns, 1996, 2008) meant that professional interests continued to dominate. It was psychiatrists who formed the advisory panels, and their voices alone were sought in addressing the inquiry's recommendations (A. Brown, 2000, 2004; W. Brunton, 2004, 2005; Nairn, 1999; Prichard, 2005). As a consequence, at this stage, there was no mobilisation of extra resources into community services. However, as the pressures continued to mount, the situation became untenable for a variety of reasons. The next decade would witness considerable mental health reform and resulting social change.

1990-1996: A period of reforms

Ideological and policy shifts under successive governments resulted in continuous reorganisation and restructuring of the New Zealand's health system in the 1990s (Ashton, Mays, & Devlin, 2005; Dalley & Tennant, 2004; Davis & Ashton, 2001; Fougere, 2001). Area Health Boards, convened in the late 1980s, were replaced by Regional Health Authorities (RHA) and Crown Health Enterprises (CHEs), previously referred to simply as hospitals, in 1993 (W. Brunton, 2004; Cheyne et al, 2000). In this era, for the first time, purchasing was separated from the provision of health services; hospitals were, ostensibly at least, no longer the privileged and preferred providers (Cheyne et al., 2000). This levelled the playing field significantly and opportunities arose for communities, NGOs, and Māori to deliver healthcare according to their own community needs, and for more innovative and socially equitable approaches to care and support to appear (Barnett & Barnes, 2010; Cheyne et al., 2000; Durie, 1999; Mental Health Commission, 1998).

ANOPS continued to provide a focal point for Aotearoa\New Zealand survivors/consumers in this era, drawing on an agenda of human rights and

empowerment, and helped to drive change in the organisation of the mental health sector (Everett, 1994; O'Hagan, 1991; Pilgrim, 2005). In addition, the traditional preoccupation with professional needs was gradually supplemented by a new concern with patient rights, and this began to undermine the autonomy of psychiatrists to make purely medical judgments about restricting personal freedoms and treating people compulsorily (Grob, 1995; Mental Health Commission, 1997).

This development was largely due to the Cartwright Inquiry into the “unfortunate experiment” at National Women’s Hospital (Coney, 1988) where Dr. Herbert Green was found guilty of unethical experimentation on women with cervical cancer; some of whom subsequently died (Cartwright, 1988; Coney, 1988). This inquiry created a wide public unease with the unlimited authority and power that had accrued to the medical profession. The subsequent Health and Disability Commissioners Act 1994 and Code of Consumer Rights (Health and Disability Commission, 1996) proved to be critically important pieces of legislations for mental health service users in this country.

New Acts: Changes in mental health policy and legislation in Aotearoa\New Zealand

The Health and Disability Commissioner Act 1994 and Code of Consumers’ Rights (Health & Disability Commission, 1996) directly challenged the paternalistic power of medical professionals and assumptions of professional benevolence (Coney, 1988; Gawith & Abrams, 2006; Mitchell, 2000). The Code, as the Act’s practical expression, generated unprecedented leverage for users of mental health services who had previously been peculiarly powerless as “consumers” of health and disability services (Paterson, 2002). Alongside other health consumers, they now had the rights to be treated with dignity, respect and cultural appropriateness as well as the right to informed consent processes and whānau or other supports when dealing with mental health professionals (Mental Health Commission, 1998b; Ministry of Health, 1994). In addition, the Health Information Privacy Code (1994) meant that people were able to access, read and annotate all information held about them. It afforded Aotearoa\New

Zealand mental health service users, for the first time, statutory rights in terms of the obligations under which health professionals must deliver care (Gawith & Abrams, 2006; Mitchell, 2000).

In addition, the Mental Health Act (1969) was reviewed, and eventually replaced, by the Mental Health (Compulsory Assessment & Treatment) Act 1992 (Ministry of Health, 1992). Submissions to the reform process included, for the first time, several hundred from newly formed consumer advocacy groups (Barnett & Barnes, 2010; Barwick, 1994; Joseph & Kearns, 1999; O'Hagan, 2004), families and other lay stakeholders (W. Brunton, 2004; Cheyne et al., 2000). The Act itself represented a significant shift towards personal freedoms as it attempted to balance the needs of wider society with the rights of the individual to appropriate care in the least restrictive environment possible (Grob, 1995; Joseph & Kearns, 1999; Ministry of Health, 2012; O'Brien et al., 2009). It also, for the first time, provided a legal definition of mental disorder, which effectively removed the power of mental health professionals to arbitrarily define mental illnesses; at the same time, it increased their accountability for overriding a person's civil rights and treating them compulsorily (Mental Health Commission, 1997a; Ministry of Health, 1994, 2012).

However, the shift to more voluntary admissions simultaneously disguised fiscal efficiencies as the major new drivers of mental health service provision. These led eventually, and inevitably, to overall reductions in the availability of supports and services (W. Brunton, 2001; Cheyne et al., 2000; Sarney, 1996). Mental health professionals were mandated by the Ministry of Health to control access to, and exit from, services according to their budgets; and this left many people and their families feeling distressed, unsupported and powerless to cope in the community. It also aggravated the so-called revolving door syndrome whereby people were discharged from in-patient services only to be re-admitted a short time later (Barnett & Barnes, 2010; Durie, 1994, 1999; Goldsack, Reet, Lapsley, & Gingel, 2005; World Schizophrenia Fellowship, 1998).

Public Scandal and mental health policy reform

Warwick Brunton (2004, 2005) has described mental health policy in Aotearoa\New Zealand as scurries of reform spurred on by the clamour of public scandals. This pattern produced incoherent, fragmented and uncoordinated changes within mental health services (Barwick, 1994; Boston et al., 1999; W. Brunton, 2004, 2005; Gawith & Abrams, 2006; Joseph & Kearns, 1996, 1999). These reforms typically withered over time and were “interspersed with long periods of stagnation and public indifference” (W. Brunton, 2005, p. 35).

Public inquiries have sometimes generated legislative change and the establishment of new subject positions (Oliver, 1992; Maguire & Hardy, 2009). This was evident in the mental health reforms in Aotearoa\New Zealand where user groups such as *ANOPS* and *Mind & Body* emerged, as did family support and advocacy groups such as *Supporting Families (SF)* and *People Relying on People (PROP)*. Perhaps most notably, the Mental Health Commission was formed in 1996, as a direct result of the third Mason Inquiry, to lead and oversee recovery based reform throughout the Aotearoa\New Zealand mental health sector. Equally, however, public inquiries have also been vulnerable to the ideological predilections of inquiry “sense makers” who interpret and implement the findings (A. Brown, 2004; Prichard, 2005; Suchman, 1995).

Scholars have maintained that many public inquiry recommendations come to rest on individual actions, focused on individual “human error” and treating events as localised or isolated incidents rather than requiring, or initiating, substantive systemic change (Ashton et al., 2005; A. Brown, 2004; O’Hagan, 1994, 2004; Prichard, 2005). These patterns reinforce the perception that, no matter the nature and scale of events that provoke inquiries, reform ultimately depends on how key stakeholders made sense of and interpret the material before them (A. Brown, 2000; W. Brunton, 2001, 2005; Prichard, 2005).

This criticism was evident in what became known as the three Mason Inquiries between 1985 and 1996 (W. Brunton, 2005; Gawith & Abrams, 2006; Vaughn & Hansen, 2004).

The Mason Inquiries and the Mental Health Commission

Judge Ken Mason, and others subsequently, maintained that interpretation and implementation of inquiry findings by powerful stakeholders routinely led to systemic persistence despite apparent policy reforms (Ashton et al., 2005; A. Brown, 2000, 2004; Cheyne et al., 2000; Gawith & Abrams, 2006; Mason, 1996; Prichard, 2005). In convening his third Ministerial Inquiry, he strongly criticised the processes of deinstitutionalisation for a lack of coordination and leadership, and noted the serious underfunding of a community sector that was unable to cope with a flood of new service users with specialised needs and issues (Gawith & Abrams, 2006; Mason, 1996; Vaughn & Hansen, 2004). Judge Mason and his team noted that, while care in the community was a policy with considerable popular support, it was compromised by the insistence that community organisations should be cheaper than state institutions and hospitals (W. Brunton, 2004, 2005; Mason, 1996).

Mason (1996) and his inquiry team also took the highly unusual step of making their own submission on the Mental Health Commission Bill (1996) in protest at the way their recommendations had been diluted by the Government's lukewarm response to the inquiry report (W. Brunton, 2001, 2004, 2005; Sarney, 1996). In the end, the inquiry team could not be ignored entirely and their intervention led to the establishment of the Mental Health Commission with a mandate to lead coordination of the sector and to undertake a stock take of existing services that would ultimately underpin the development of the document: *The Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998).

Despite the Inquiry team's frustration at the government retaining control of funding, the Commission was able to ring-fence a funding stream, dubbed the "Mason money", which initiated systemic training and resourcing of the community sector (Ashton, 1999; Barnett & Newbury, 2002; Caird, 2001; Gawith & Abrams, 2006; Warriner, 2001). In the years that followed, the Commission also published, and invited publications from, a wide range of commentators. These publications represented a major source of authorship

from outside mainstream psychiatry, made particularly compelling by some authors being not only mental health professionals, but also identifying as having experienced extreme, and distressing, mental states (Leibrich, 2000).

In the meantime, Aotearoa\New Zealand also undertook radical reforms of the whole health sector in the 1990s. These reforms were an attempt to devolve health services to the “market” and brought with them a discourse of managerialism to replace professional authority in health and mental health (Ashton, 1999; Ashton et al., 2005; Cheyne et al., 2000; Joseph & Kearns, 1996; Reay & Hinings, 2005). Discourses of health outcomes were subjugated to issues of public expenditure, productivity and cost effectiveness meaning that “the principles of deinstitutionalisation became subsumed within the neoliberal logic of restructuring” (Joseph, Kearns, & Moon, 2008, p. 79). Overall, the reforms of the 1990s were characterised by conflicting impulses, with some significant intersections and unanticipated consequences.

Managerialism, consumerism and paradox in health service reform

The New Zealand health reforms became renowned internationally as trend-setting within a politically right wing, capitalist agenda (Ashton, 1999; Ashton et al., 2005; W. Brunton, 2004, 2005; Cheyne et al., 2000). The adoption of an overtly managerialist approach to healthcare and the promotion of state contracting for health service provision seriously affected mental health services (Boston, 1996; *Platform Trust*, 2008). The primary focus on “taking care of business” led inevitably to corporate style practices and management models. These were evident in the establishment of the Crown Health Enterprises (CHE) which operated under the governance of the Regional Health Authorities (RHA) (Ashton, 1999; Ashton et al., 2005; Barnett & Newbury, 2002). These changed the nature of, and accountability for, health service provision from health outcomes for service users to maximising investment for owners and shareholders (Reay & Hinings, 2005).

Most importantly, this restructuring institutionalised the shift from the government as *funder* of health services to *purchaser* of health services, which

engendered a separation between funding and service provision intended to promote better financial management, greater efficiencies and accountabilities (Ashton, 1999; Boston et al., 1999; Fougere, 2001; Kirkpatrick & Lucio, 1996). However, this also created considerable tension between new discourses of accountability to funders and taxpayers at the expense of accountability to actual health service users (Fougere, 2001). In addition, corporate management models were frequently in conflict with therapeutic approaches, and competitive funding, intended to drive down the costs of services, created an environment of mistrust between service providers and a lack of coordination throughout the sector (Ashton et al., 2005; Fougere, 2001). The quality of services necessarily suffered, particularly in the community and NGO sector, which already struggled for funding and credibility. In the event, no financial gains were ever observed (Ashton, 1999; Ashton et al., 2005; Boston, 1999).

However, the introduction of the quasi-market language of “consumerism” in health provided an unexpected opportunity for psychiatric survivors who were clamouring for participation and voice in the ideological development of mental health service configuration (O’Hagan, 1991, 2004; Paterson, 2002). The different ideo-political positions shared an emphasis on consumer rights, albeit from very diverse discourses, which resonated sufficiently with the Government to enshrine into law a Code of Consumer Rights (Health and Disability Commission, 2009) that effectively gave mental health service users unprecedented rights to be involved in decisions about their treatment and care.

Ultimately, the corporatisation of health and the creation of health “consumers” in Aotearoa\New Zealand failed as a political experiment but left a legacy of purchasing and contracting models in the administration of healthcare, including mental health (Boston et al., 1999; Fougere, 2001; Kirkpatrick & Lucio, 1996; Tennant, O’Brien, & Saunders, 2008). Nevertheless, new ways of thinking about mental health services meant that the voices of service users, families and Māori were somewhat strengthened in the development of service definitions and outcome evaluation. In addition, new conceptual models such as recovery,

Te Whare Tapa Wha (Durie, 1985, 1994) and the Strengths model (McCashen, 2005; Rapp, 1998; Saleeby, 2002) became instrumental in developing service delivery frameworks that created some space for the agency, aspiration and resourcefulness of service users (Anthony, 1993; Copeland, 1997; Deegan, 1988, 1996; Harter et al., 2006; Jacobson & Greenley, 2001; O'Hagan, 1999).

1996- 2000: Recovery, a new discourse emerges

The gradual emergence of recovery as a significant new paradigm in mental health services accompanied a growing social awareness that psychiatry could no longer claim a privileged understanding of mental illness or psychological distress (Bracken & Thomas, 1998). The development, and eventual publication, of the document, *The Blueprint for mental health services in New Zealand: The way things need to be* (1998), was unique for mental health policy in Aotearoa\New Zealand because it incorporated the perspectives of people with lived experiences of psychological distress, their families, and Māori, all of whom had been disregarded previously in the development of mental health services (O'Hagan, 2004; Durie, 1999; Mental Health Commission, 1998; Ministry of Health, 1994).

Adopting recovery into national policy represented the first rational basis for coordinating the development and delivery of mental health services and care in this country. As it was defined in *The Blueprint* (Mental Health Commission, 1998), this recovery discourse was underpinned by certain explicit assumptions. First, it affirmed the rights of all people to their own aspirations for well-being and a satisfying quality of life. Second, it supported people's right to a sense of personal power in making the important decisions in their life, and third, that all members of a community have a right to participate fully in that community with equitable access to its resources and opportunities (Mental Health Commission, 1998, 1999; Ministry of Health, 1997).

The definition of recovery used in the introduction was based on definitions offered by Laurie Curtis (1997) and Patricia Deegan (1988). Central to this construction was that:

Services must empower consumers, assure their rights, get the best outcomes, increase their control over their mental health and well-being, and enable them to fully participate in society. This focus on recovery reflects the shift of thinking which is happening throughout the sector (Mental Health Commission, 1998, p. vii)

However, controversially, and reflecting the clinical professional influences within the Commission, the reification of mental illness was naturalised throughout the text, despite other constructions or health beliefs being acknowledged (Mental Health Commission, 1998).

Recovery was neither a new, nor a unique, concept. However, from its inception the concept of recovery in mental health was plagued by ambiguity and controversy.

History of recovery discourse

Adoption of a discourse of recovery in the *Blueprint* (Mental Health Commission, 1998) was controversial. Although Aotearoa\New Zealand was the first country in the world to incorporate recovery into national policy, contested uses of the term meant its inclusion was only reluctantly agreed to by the users of mental health service at that time (Adams et al., 2009; O'Hagan, 2004, 2009). They had serious reservations about multiple discourses of recovery, which appear prophetic over 15 years later (*Central Potential*, 2008; Coleman, 1999; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; O'Hagan, 2004; Wallcraft, 2009).

At the time, stakeholders were concerned about the colloquial uses of the term "recovery", as well as its construction in the Alcohol & Drug field, where the underpinning principles of a disease model were unacceptable to many mental health service users (Coleman, 1999; Deegan, 1988; Leibrich, 2000a; Pearson, 2004). Mary O'Hagan (2004), at this time, said that doubts about the word recovery were mostly directed at the North American version that

emphasised the *personal*, and ultimately more individualistic, journey of recovery.

In contrast, Aotearoa\New Zealand stakeholders were determined to incorporate the social, economic and political dimensions of their experience; and to replace the biomedical, deficits approach with an explicit platform of self-determination. New Zealand “consumers” also believed that service users should lead recovery, not professionals (Gawith & Abrams, 2006; Mitchell, 2000; O’Hagan, 1999, 2004, 2009c; Pearson, 2001, 2004; Jacob Read, 2003a). With no generally accepted definition, recovery remained a contested, and controversial, concept (Coleman, 1999; O’Hagan, Reynolds, & Smith, 2012).

The two major discourses of recovery emanated from significantly distinct sources. The bio-psycho-social, or rehabilitation, model of recovery tended to be championed by the “other” mental health professionals such as psychiatric nurses, occupational therapists and social workers (Barber, 2005; Barker & Buchanan-Barker, 2011; O’Hagan, 2004; O’Hagan et al., 2012; Pilgrim, 2002). These groups, while eager to distance themselves from a purely biomedical stance, were still “insiders” of the prevailing orthodoxy and tended to remain faithful to reified constructions of mental illness and diagnoses. They defined recovery as rehabilitation, or the restoration of “normal” health and functioning. This version had implications not only for the evolution of recovery discourses but also served to maintain privileged interests and relationships of power in the mental health sector.

In contrast, the New Zealand “consumer” discourse of recovery rejected outright a biomedical discourse of deficits, symptoms and problems and emphasised the social, political and cultural aspects of recovery. These groups maintained that “recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination” (Mental Health Commission, 1998, p. 1). This discourse also required a major paradigm shift in how mental health service workers perceived their roles and how services and contracting processes should be configured, and outcomes

measured (Banks et al., 2004; Barber, 2005; *Central Potential*, 2008; Pearson, 2002; Warriner, 1997, 2001).

The recovery discourse that emerged through the personal narratives of psychiatric survivors\consumers stated clearly that professional intervention must be experienced as beneficial, not harmful, for it to be warranted. For many who had been through the psychiatric systems of most Western nations, the opposite had almost inevitably been the case (Adame, 2006; Gawith & Abrams, 2006; Leibrich, 2000; O'Hagan, 1994, 1999; O'Hagan et al., 2012). Advocates of this subjective, experiential discourse positioned the ordinary community, rather than mental health services, as the appropriate setting for people to regain their rights of citizenship and reconnect with social networks that enhanced their sense of belonging (Agnew et al., 2004; Barber, 2005; Blundo, 2001; Durie, 1985; McCashen, 2005; Warriner, 2001). Prominent commentator Patricia Deegan (1988, 1996), among others, took issue with the politics of "inclusion" where this conferred power on the "community" to define the rules for social participation (Carling, 1995; Leibrich & Carson, 2012; Oliver, 1998; Perkins & Repper, 2003; Sayce, 2000, 2001; Spandler, 2007; Vaughan & Hansen, 2004).

As time went on it became more difficult to discern an authentic recovery discourse in Aotearoa\New Zealand mental health organisations. Professional and other stakeholder groups endeavoured to claim their own versions of recovery in order to rationalise their existing service provision and practice approaches (Bonney & Stickley, 2008; Davidson et al., 2006; Lehman, 2000; Mancini, Hardiman, & Lawson, 2005; Mental Health Commission, 2011b; Wallcraft, 2009). This had serious implications for the development of recovery-oriented community organisations and mental health services generally. The *organising* of recovery will be discussed in the literature review following but suffice to say at this point that several commentators began to refer to the *colonisation* of recovery (Barker, 2003; O'Hagan, 2009a; Ridgeway, 2001; Wallcraft, 2009).

Emerging discourses challenge biomedical constructions of madness

Despite these tensions, the concept of recovery resisted the biomedical discourse in many ways. First, it challenged the categorisation of experience; not merely the negative impacts of diagnostic labelling and the systemic classification of deeply personal experiences but, more generally, the pathologising of human distress (Carson, 1997; Jureidini, 2012; Leibrich, 1997; O’Hagan, 2010; Pilgrim, 2007; Scheff, 1974). Second, people with lived experience of psychological distress were vociferous about their right to define and name their own experience (Deegan, 1990; Fisher, 2000; Leibrich, 2000; O’Hagan, 2010); particularly after decades of dealing with the “removal of their competence and power” (O’Hagan, 1994). For them, creating a life worth living was a fundamentally different goal to the “cure” of mental “illness”. Similarly, these commentators challenged the over-emphasis, in services, on personal change to the neglect of social systems change (Deegan, 1996; Foucault, 1973; Lord, Ochacka, Czarny, & MacGillivray, 1998).

Over time, the language of recovery evolved in important ways. This was evident in new authorship and subject positions as well as being reflected in the changing dynamics of the socio-political environment (Anthony, 1993; Becker et al., 1998; Bonney & Stickley, 2008; Carling, Allott, Smith, & Coleman, 1999; Torrey, 1997, 2000). For example, the identification language of the *psychiatric survivor* of mental health services became absorbed by the discourse of *consumers* and then *service users* in health services (O’Hagan, 2012) with many finally preferring the expression *people with lived experience of extreme distress*. In New Zealand, culturally embracing terms such as *tangata whaiora*¹¹ reflected the adoption of indigenous, holistic frameworks of health and well-being such as *Te Whare Tapa Wha* (Durie, 1985, 1999) and *Fonofale* (Agnew et al., 2004; Pulotu-Endemann, 2001). In contrast, professionals and services increasingly referred to users of their services as *clients* (Anthony, 1993; Duncan et al., 2000;

¹¹ Tangata whaiora is a Maori phrase, literally ‘person following wellness’

Torrey, 1997, 2011) indicative of the encroachment of managerialism in health. Each iteration, therefore, expressed a distinct voice and perspective.

Meanwhile, orthodox psychiatry tended to react defensively to these challenges (Craddock et al., 2008; Kendell, 2000; Mountain & Shah, 2008; Torrey, 1997) and the formal introduction of recovery into national policy was not, in itself, sufficient to remove the legal, coercive and conventional treatment aspects of service provision and development (Barker, 2003; O'Brien & Golding, 2003; O'Brien et al., 2009; O'Hagan, 2004; Wallcraft, 2009).

In New Zealand the *Like Minds, Like Mine* media campaign (Mental Health Commission, 1998b) sought to raise public awareness about how people's identities, sense of self and perception of their social value were shaped by their encounters with the community. The campaign emphasised that stigma became a kind of self-fulfilling prophecy for people with lived experience of psychological distress (Luske, 1990; Oliver, 1996; Vaughan & Hansen, 2004). Through such campaigns it became more widely accepted that there was a need for social, as well as individual change, and that recovery could not take place in environments where people were isolated from meaningful connections to their communities (Carling, 1995; Sayce, 2000; Spandler, 2007; Sullivan, 1992; Warriner, 1999, 2001). In general, media initiatives appeared to be more influential than policy change in shifting public awareness and attitudes that limited people's participation in their communities (Ackroyd & Wyllie, 2002; Gawith & Abram, 2006; Vaughan & Hansen, 2004).

By the year 2000, in the aftermath of "deinstitutionalisation", mental health services, policy makers and the community alike were confronted with the uncomfortable reality that people need more than symptom relief to regain an ordinary life in their community (Anthony, 1993; Barber, 2005; Deegan, 1996; Jacobson, 2001; Lapsley & Nikora, 2002; Leibrich, 1998, 2000; O'Hagan, 1999; Pescosolido et al., 1995). People recovering from the disorienting impacts of their experiences needed environments and supports, including services, that enabled them to re-establish, reconstruct and manage their lives within the communities of their choice.

The community comes into its own

The separation of funding from the provision of services in the RHA and HFA era of the late 1990s had provided a more level playing field for community NGOs. New models of community care and community support work emerged as the focus shifted to community locations and community ideals (Caird, 2001; Durie, 1998, 2001, 2009; Dyall, 1997; Kukler et al., 1998; Roen, 1999; Wade, 1999; Warriner, 1999). More flexible funding arrangements and the so-called Mason money meant the community organisations were able to engage in training and professional development, and a new qualification, the National Certificate in Mental Health Support Work, was developed. Riding a wave of “consumer” rights meant that individuals, communities and the NGOs could negotiate resources for local solutions, community initiatives and even consumer driven service provision (Joseph et al, 2009). It was an era propitious for innovative service development.

For the first time, there was also direct funding of “consumer” or “psychiatric survivor” led organisations, which were then able to establish themselves and flourish (Barber, 2005; Caird, 2001; *Central Potential*, 2008; O’Hagan, 1991; Wade, 1999). Other new organisations were founded by occupational groups such as psychiatric nurses and occupational therapists, who needed new employment post-“deinstitutionalisation”. These NGOs foresaw opportunities to respond actively and positively to policy shifts and establish alternatives to hospital-based treatment. They were typically informed by more psychosocial approaches (Harrison, 2010; Kukler, 1999; Sanders, O’Brien, Tennant, Sokolowski, & Salamon, 2008; Warriner, 1999, 2001).

The strengthening community sector was also able to advocate for, and articulate, a role for community support work (Barber, 2005; Caird, 2001; Pulotu-Endemann, 2001; Kukler, 1999; Roen, 1999; Wade, 1999; Warriner, 2001). However, there was tension between models of community support work developed in organisations established by allied professionals and the nature of effective support identified by the consumer movement (Leibrich, 1998; O’Hagan, 1999; Pearson, 2000, 2002). This tension had important implications

for the values, vision and practices of the community organisations (Barber, 2005; Caird, 2001; Kukler et al., 1998; Wade, 1999). In particular, the former tended to emphasise a rehabilitation approach that focussed on coping skills, stress management, relapse prevention and the development of functional social competence (Caird, 2001; Ministry of Health, 2001b; O'Hagan, 2001).

In contrast, organisations influenced by consumer experience of psychological distress and clinical treatment services, were focussed on supporting people's aspirations in education, employment, relationships and service leadership. They were also concerned with addressing stigma, in both mental health services and the wider community, and advocating for social change (*Central Potential*, 2008; Chamberlin, 1998; Clark & Krupa, 2002; Gawith & Abrams, 2006; Pearson, 2000).

These circumstances led Rob Warriner, among others, to warn that mental health services in Aotearoa\New Zealand lacked an explicit vision and coherent philosophical framework. In particular, he argued that "the development of community-based mental health services in this country is lacking core values, an explicit set of shared beliefs and philosophical foundations upon which they can be built" (Warriner, 2001, p. 15). In addition, and despite the rapid evolution and growth of the community sector, the contribution of the NGOs remained largely undervalued and their potential untapped (Health & Disability Commission Working Group, 2010; MHAC, 2008; Ministry of Social Development, 2001). All of this meant that these organisations, despite being acknowledged as innovative and proactive in promoting recovery outcomes (Mental Health Commission, 2007b; Warriner, 2001; Peters, 2010; MHAC, 2008; Harrison, 2010), struggled to establish a unique identity, or niche, as politically legitimate and credible alternatives to more dominant systems and ideological forces (Barnett & Newbury, 2002; Kukler, 1999; Ministry of Health, 2001; Ministry of Social Development, 2001).

2000-2014: Recent issues and important trends

By the beginning of the new millennium in Aotearoa\New Zealand, the HFA, RHAs and CHEs had all become historical acronyms. This meant that, despite remaining formal policy, the halcyon era for developing recovery oriented mental health organisations effectively came to an end with the establishment of regional District Health Boards (DHBs) in 2000 (Ashton, 1999; Ashton et al., 2005; W. Brunton, 2005; Cheyne et al., 2000; Warriner, 2001, 2010). This new arrangement meant that DHBs, as both funder and providers of services, were able to determine, unilaterally, the configuration of all mental health services within their region (Ashton et al., 2005; W. Brunton, 2005; Tennant et al., 2008). This reconfiguration did little to suppress neoliberal ideologies, i.e. “the best service at the best price”, and the elevation of private interests over public good, continued to underpin healthcare generally (Dutta, 2015; Frumkin & Andre-Clark, 2000; Joseph et al., 2009; Kearns et al., 2003).

The “new right” ideological stance, which underpinned the controversial contracting environment, was accompanied by a return to risk-averse management practices (Harrison, 2010; Mental Health Commission, 2004b; *Platform Trust*, 2008; Sawyer, 2005) and a renewed increase in clinical oversight of community services. Together these trends further reinforced the commodification of health and disability (Barnett & Newbury, 2002; Kendrick, 2012; Oliver, 1998).

In addition, as Warriner (2001) argued, “the underlying and potentially destructive tension [that] exists between the medical model and more recent, contemporary models of mental health service delivery has been an outcome of the lack of a clear, underlying and shared philosophical ethos” (p. 21). Julie Leibrich argued further, that the current system has made it impossible for people with lived experience of psychological distress to live normal lives, and then labelled them *ab-normal* (Leibrich, 1998). She, and other commentators, have remained critical of mental health services that have systematically disempowered people and then accused them of not taking charge of their lives; refused to give them work but then declared them unemployable; prevented

them from living in nice places but then stigmatised them for living in squalor (Leibrich, 1998).

Recovery and the institutions in the Aotearoa\New Zealand context

Despite the discourses of recovery being explicit in organisational missions, strategies and national policy, many things worked against its expression in organisational practices. The contracting parameters and accountabilities for NGOs increasingly reflected managerialist and biomedical preoccupations. This created significant tensions between the values and philosophies of the community organisations in terms of their constitutions and Trust deeds with those of DHB clinical provider and funder arms. Several commentators, including those from within psychiatry, were further concerned that some mental health services simply relabelled themselves as recovery-oriented but did not fully engage with the challenge of organisational transformation, and the fundamental shifts in paradigm, structure and organisation that this required (Davidson et al., 2007; O'Hagan, 2004, 2009c, 2012; Pearson, 2004; Leibrich & Carson, 2012). Others highlighted the tendency to adopt the language of recovery but to recreate the institutions, and their operational paradigms, within community settings (Barber, 2005; Barker, 2003; Warriner, 2001, 2010; Wallcraft, 2009).

Many attributed the dilution of recovery, in national policy documents (Ministry of Health, 2005, 2006; *Platform Trust*, 2007), to the ascendancy of managerialism in health and the renewed emphasis on biomedicine in the 1990s, dubbed the "decade of the brain" by US Congressional Resolution in 1991 (Anthony, 1993; Craddock et al, 2008; Frumkin & Andre-Clark, 2000; Pilgrim, 2002; Torrey, 2011). In addition, resourcing for mental health services was no longer ring-fenced within DHB operational budgets, leaving the community NGOs more vulnerable than ever. This returned the community organisations to an explicitly subordinate position; competing for funding in an environment where the single funder was also responsible for the provision of clinical services (Harrison, 2010; Peters, 2010; *Platform Trust*, 2008; Warriner, 2010).

Growth in the community sector was also constrained by service contracts that included an increasing insistence on risk aversion and clinical oversight (Harrison, 2010). Heightened government scrutiny, demands for accountability, and increased competition for contracts and resources accompanied a managerialist emphasis on “professionalism” (Boston et al., 1999; Chetkovich & Frumkin, 2003; Frumkin & Andre-Clark, 2000; *Platform Trust*, 2008). So even though innovation continued in the community organisations, they became increasingly vulnerable to arbitrary decision making by DHB clinical and funding teams (Harrison, 2010; Peters, 2009; McMorland et al., 2008; Warriner, 2001).

The re-organising of mental health services and the contracting environment in Aotearoa\New Zealand

Despite managerialist assumptions of better financial management, greater efficiency and accountability in a contracting environment (Barnett & Newbury, 2002; Kirkpatrick & Lucio, 1996), the expected gains and cost reductions were never realised (Ashton et al., 2005; Cheyne et al., 2000; Harrison, 2010; *Platform Trust*, 2008; Tennant et al., 2008). In fact there was evidence that service performance actually declined and commentators noted that despite surface changes the system eventually re-established itself into familiar patterns of power (Ashton et al., 2005; Barnett & Newbury, 2002; A. Brown, 2004; Prichard, 2005).

Criticisms of the contracting environment included the lack of collaboration in strategic service development, as well as the diminishing independence of the NGOs in their relationships with the DHBs and the Government (Harrison, 2010; Warriner, 2010). There were also concerns that contracting processes varied from region to region and, in some DHB regions, the contracting environment was actively hostile to community providers (Harrison, 2010; *Platform Trust*, 2008). This engendered a culture of compliance rather than collaboration in organisational relationships and reinforced the relationships of power between clinical services and the community sector (Argyle, 2005; McMorland, et al., 2008; Peters, 2009).

Non-government sector forums such as *Platform Trust* were established, and endeavoured to coordinate research, advocacy and lobbying efforts in order to provide a voice for NGOs and their role in service delivery (Harrison, 2010; Peters, 2010; *Platform Trust*, 2007, 2008). But these had variable efficacy and a systematic devaluation of these groups became apparent over time (Harrison, 2010; Lerner & Craig, 2005; McMorland et al., 2008; Ministry of Social Development, 2001). Nevertheless, the sector continued in their attempts to articulate a unique niche within the spectrum of Aotearoa\New Zealand mental health services. Initiatives were supported by the Mental Health Commission, which noted that a well-defined, articulate community non-government sector was key to the growth of the mental health system in this country (Mental Health Commission, 2004; Warriner, 2010).

Various innovative service models were established in some organisations and regions (*Central Potential*, 2008; Ley et al., 2010; Mead et al., 2001; Peters, 2009). These included intentional peer support services (Mead, 2005); peer support teams within NGOs (Scott et al., 2011; Repper & Carter, 2011) and peer run acute and respite services (Peters, 2009; Scott et al., 2011). Collaborative ventures with clinical services were undertaken in Counties Manukau (McMorland et al., 2008; MHAC, 2008; Peters, 2010) and several exciting initiatives were trialled in Wellington (Peters, 2009). Unfortunately, these opportunities were not possible in all areas and tended to be isolated instances rather than indications of systemic change (MHAC, 2008; Peters, 2010).

Over time, devaluing the role of NGOs was accompanied by similar demotion of other sector stakeholders, most notably the Mental Health Commission. The Commission originally comprised three commissioners, at least one of whom was required to be a person with lived experience of psychological distress (Mental Health Commission, 1998). Dr. Julie Leibrich, Mary O'Hagan and Arana Pearson, all leading figures and authors in New Zealand's consumer movement have taken up this role over the years. However, this requirement was removed in 2010, shortly before the National Government disestablished the Commission itself in 2012.

In addition, Aotearoa\New Zealand has followed global trends, driven largely by private health insurers in the USA, and increased the emphases on risk-management and evidence-based practices in services (Anthony, Rogers, & Farkas, 2003; Manderscheid, 2006; Thomas et al., 2005). This has contributed to a fundamental tension between the recovery outcomes identified by service users and those of other stakeholders (Anthony et al., 2003; Bond et al., 2001; Duncan et al., 2005; Farkas, Gagne, Anthony, & Chamberlin, 2005; Salyers & Macy, 2005; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005).

Furthermore, the symbiotic relationship between pharmaceutical companies and medical prescribers, established mainly through industry-funded research has caused much concern, even within psychiatry (Moncrieff, 2007; Pilgrim & Rogers, 2005). Commentators have warned that commercial pressures and marketing strategies, rather than progress toward some new biomedical truth, are guiding prescribing practices. Unfortunately, medication has remained a cheaper, more “efficient” treatment option, and talking-based therapies, crisis interventions, intensive family supports and other psychosocial programmes remain limited and variable in their availability throughout the country.

Recovery outcomes valued by service users, such as therapeutic supports, quality of life and community connectedness, have been notoriously difficult to measure and attribute to specific organisational practices, making them less easy to monitor than so-called scientific measures (Anthony et al., 2003; Frese, Stanley, Kress, & Vogel-Scibilia, 2003; Frumkin & Galaskiewicz, 2004; Torrey et al., 2005). Critics have countered that being less measureable does not necessarily mean less valuable; but these arguments have held little sway (Duncan et al., 2005; Hubble et al., 1999). Instead, DHB requirements for statistical evidence have become an increasing, administrative burden for the NGOs and severely curtailed their endeavours to be innovative, responsive, and, ultimately, recovery-oriented (Kanter & Summers, 1994; Lewis, Passmore, & Cantore, 2005).

Despite ostensible gains in more holistic approaches to treatment and support, including recovery, service users and others have continued to criticise

the mental health services and have begun to refer to recovery as fatally compromised (Barker, 2003; O'Hagan, 2009a; Ridgeway, 2001; Wallcraft, 2009). Some have adopted a new discourse of "well-being" in an attempt to control the discourse and subjective meanings of their experience (Ganesh & McAllum, 2010; O'Hagan, 2009; Sointu, 2005, 2006). Mary O'Hagan (2009a) has stated that the discussions about replacing recovery with well-being promotion, are not because it is necessarily conceptually more advanced, but because she and others believe that recovery has been "diluted and colonised to fit a system that continues to be deficits based, over clinical, over controlling, and ghettoised" (p. 20).

Conclusion

In this chapter, I have brought together the wide range of influences that have woven the backdrop to contemporary mental health organisations in Aotearoa\New Zealand. In particular, it is very apparent that, historically, the treatment of madness has always been peculiarly vulnerable to political, ideological and socio-economic circumstances. These have not only driven the discourses of mental health and illness, but have also been the shifting sands upon which mental healthcare organisations have struggled to establish a stable footing.

Unsurprisingly, there have been inevitable tensions among the social control function of mental health services, therapeutic care and individual human rights. Typically, these organisations have been socially and legally mandated to focus on the "normalisation" of difference and deviance and the imperative to serve the wider interests of the community has generally been more compelling than protection of rights of citizenship. Despite recent global shifts, towards more humane and socially constructed conceptualisations of the meanings of extreme emotional experiences, a strong tendency to endorse the bio-medical model as received truth has remained, and this has determined the orthodoxy, and defined the discourses, of mental illness and its treatments in Aotearoa\New Zealand as throughout the Western world. It has also directed

and dominated research, policy and strategy in the organisation of mental health systems for over a century.

Over the last few decades, other social forces became persuasive in re-orienting paradigms of care and support. This initiated the slow devolution of mental health services to community settings; a process commonly referred to as “deinstitutionalisation”. Gradual reforms saw the eventual closing of the large, psychiatric “institutions” on the presumption that “seriously mentally ill persons” would transition to community life with appropriate supports. However, the psychiatric professions maintained their authority throughout, and their definition of “community” led to an overemphasis on geographical location and “normal” functioning as the principle features of “community care”; rather than disruption of the discourses or activities of biomedical psychiatry.

The phenomenon of deinstitutionalisation, therefore, has remained discursively complex, as has the notion of community care. For many mental health service users, in Aotearoa\New Zealand as elsewhere, a rich sense of the lived experience of community remained just a glimpse through the looking glass, mediated by economic and political circumstances and characterised by poverty, transience and powerlessness. Additionally, despite the rhetoric of most mental health services that they exist solely to benefit a person’s aspirations and well-being, pragmatically, the needs, priorities and interests of service users have always struggled in the face of more powerful voices and interests.

The last twenty years has witnessed the evolution and growth of the community NGOs into a loosely federated sector in Aotearoa\New Zealand. This has occurred alongside a growth in service user advocacy groups and the introduction and evolution of new subject positions in the mental health sector generally. In particular, the personal narratives of psychiatric survivors, and others with personal experience of psychological distress have gradually strengthened the voices, and political identities, of service users, their families, and allies in the development of conceptual models for organisational practice, service definitions and outcome evaluations. These accounts provided

alternative explanatory models to better understand and share their experiences of madness and not only challenged traditional paradigms of diagnosis and treatment but led to the establishment of peer support services, primarily in the NGOs, and advocated for leadership roles in the transformation of mental health organisations towards a recovery orientation.

Most commentators have agreed that a recovery orientation in the configuration of mental health service organisations would look very different from those that narrowly define successful outcomes as symptom control or functional, coping skills. The community mental health NGOs have appeared to be uniquely positioned to provide innovative service models, being typically mandated by their trust deeds and constitutions to provide a range of social supports intended to facilitate their access to the resources and opportunities of ordinary community living. However, despite a national policy mandate of recovery in the development and delivery of the Aotearoa\New Zealand mental health sector, this has appeared difficult to achieve in practice. Many commentators believe that, while the language of recovery has been adopted in policy reforms and service descriptions, it has been assimilated into other discourses rather than becoming a powerfully constructed and effective alternative paradigm guiding service development, policy and practice.

Worldwide, mental health services have demonstrated historical patterns of being underfunded, under-resourced, catchall services and sufferers have typically existed on the margins of society. Equally, mental health policy, strategy and service development have not captured public interest for long and have been characterised by intermittent public scandals followed by brief periods of reform; all of which reinforces the importance of undertaking this current investigation into the nature and communication efficacy of the community NGOs in Aotearoa\New Zealand, and their capacity to realise their best intentions to become recovery-oriented.

In the next chapters, therefore, I first map the theoretical terrain of critical approaches to the communication and organisation of mental healthcare, especially in Aotearoa\New Zealand although, inevitably, this draws on

discourses prevalent in the Western world generally. This then provides the grounds for Chapter 4, which is a critical examination of the literature that underpins the constitution of mental health service delivery in Aotearoa\New Zealand, and in particular the community NGOs.

Chapter 3: The theoretical terrain

Introduction

Many scholars have been critical of positivist orthodoxy in healthcare (Dutta & Zoller, 2008; Harter, Japp, & Beck, 2005; Harter, Patterson, & Gerbensky-Kerber, 2010; Pilgrim & Rogers, 1999; Rappaport, 1990) particularly as it is applied to mental health services (Jureidini, 2012; Nelson et al., 2001; John Read et al., 2004; Szasz, 1960, 1974). However, most of these critiques have occurred outside biomedicine and psychiatry. Therefore, in this chapter I proceed by first outlining the fields of scholarly interest in the organisational communication of mental healthcare, and the rationale for a critical approach to this subject that, in turn, guides the review of literature that follows.

Fields of interest

The fields from which this thesis draws, in addition to organisational communication, include medical sociology (Pilgrim & Rogers, 1999, 2005a, 2005b), health communication (Dutta & Zoller, 2008; Zoller & Kline, 2008), psychology (Duncan et al., 2004; Hubble et al., 2009; John Read, 2005) and social work (Rapp, 1998; Rappaport, 1987, 1990, 1995; S. Rose, 2000; S. Rose & Black, 1985; Saleeby, 2002). There has also been a growing body of recovery literature, much of it originating from people who themselves have experiences of serious psychological distress (Copeland, 1997; Curtis & Hodge, 1994; Deegan, 1988, 1998; Fisher, 2000; Jacobson, 2001; Leibrich, 2000b; O'Hagan, 2004; Pearson, 2002, *among many others*)

Medical sociology has been especially concerned to scrutinise the close relationship between power and knowledge in healthcare (Pilgrim & Rogers, 2005a, 2005b) as well as the societal organisation of healthcare and its relationship to the state and political economy (Foucault, 1963, 1970, 1972, 1973; Oliver, 1996, 1999; Pilgrim & Rogers, 1999; S. Rose, 2000; Turner, 1995; U'Ren, 1997). Scholars in this field have critically examined the increasing

medicalisation of social issues (Foucault, 1963, 1972; Pilgrim & Rogers, 1999; Samson, 1995; Turner, 1995) and the rise of medical power (Conrad & Schneider, 1990; Frances, 2013; Pilgrim & Bentall, 1999; N. Rose, 1999; Samson, 1995; Turner, 1995), the role of medical professionals as agents of social control (Foucault, 1963; Hwang & Powell, 2009; Pilgrim & Rogers, 2005c; Scott, 2008; Waitzkin, 1989, *among others*), as well as socio-political phenomena such as “deinstitutionalisation” (W. Brunton, 2001; Clemente & Roulet, 2015; Fakhoury & Priebe, 2002, 2007; Grob, 1995; Joseph & Kearns, 1996; Sawyer, 2005).

The field of health communication has been similarly concerned with the tensions among subjective experience, situated meaning formations, and the communicative relationships between laypersons, professionals and the public. These scholars are interested in how health knowledge is constructed, embedded and organised within generalised discourses that underpin and express society and social life (Babrow & Mattson, 2003; Dutta & Zoller, 2008; Harter et al., 2005; Lammers, Barbour, & Duggan, 2003; Zoller, 2011, 2012; Zoller & Dutta, 2008; Zoller & Kline, 2008).

Complementing these approaches, critical organisation theory has further developed scholarly understanding of organisational phenomena with reference to the explicit and dynamic relationship between organisations and the societies to which they are inextricably linked (Deetz & Kersten, 1983; Mumby & Stohl, 1996, 2007); through boundaries that are inevitably “permeable and in flux” (Mumby & Stohl, 1996, p. 65). Critical management (Alvesson & Deetz, 2000; Alvesson & Willmot, 1992) and organisational communication scholars (Deetz, 1992a, 1992b; Deetz & Mumby, 1990; Ganesh, 2008, 2010; Mumby, 1988, 2008; Mumby & Stohl, 1996, 2007) have examined how discourses become socially legitimate and powerful (Fairclough, 1992; Foucault, 1970, 1972, 1980; Maguire & Hardy, 2009). They have also been interested in how ideas, and ideologies, transfer across organisational boundaries (S. Brown, 2002; Maguire & Hardy, 2009; Venuti, 1992, 2004; Zilber, 2002, 2006) and how these privilege some groups while marginalising others; constructing identities that are more or less powerful and valued in their social world (Alvesson, Ashcraft, & Thomas, 2008;

Ashcraft & Pacanowsky, 1996; Holmer-Nadesan, 1996; Honneth, 2002; Schneider & Remillard, 2013; Trethewey, 1997; Ward, 2009).

Institutional theorists, too, have explored the mechanisms by which institutions, such as biomedicine and managerialism, persist (Barbour & Lammers, 2007; DiMaggio & Powell, 1983, 1991; Frumkin & Galaskiewicz, 2004; Lammers, 2011; Meyer & Rowan, 1991; Schneiberg & Lounsbury, 2008; Suddaby & Greenwood, 2001) and change (Creed, Scully, & Austin, 2002; Fakhoury & Priebe, 2007; Maguire & Hardy, 2009; Oliver, 1992). Although many of these studies appear to ignore critical issues of power within institutional systems (Mumby, 1998, 1997, 2005) and are more interested in how these maintain and reproduce themselves over time, nevertheless, they point the way to understanding more about mechanisms for institutional disruption and destabilisation (Maguire & Hardy, 2009; Zilber, 2002, 2006).

All of this scholarship is of value for researchers interested in social constructions of mental health, mental illness and related concepts such as recovery, community and empowerment. For these researchers, the mechanics of destabilising biomedical orthodoxy and establishing alternative discourses in mental health systems is paramount (Duncan et al., 2004; Durie, 2009; Rappaport, 1995, 2002; N. Rose, 1996, 2006; S. Rose, 2000; S. Rose & Black, 1985). Many of these scholars represent a burgeoning group, from within the mental health sector, who identify as “consumers” of services, or people with lived experience of serious psychological distress. They have added their personal accounts of mental “illness” and the treatment they received in services to the literature (Deegan, 1988; Fisher, 1994a, 1994b, 2000; Leibrich, 1998, 2000a; O’Hagan, 1994, 1999; Pearson, 2004; Ridgway, 2001 *among many others*).

These emerging scholars have had support from two important movements over several decades: anti-psychiatry in the 1960s (Breggin, 1993; Laing, 1960; Szasz, 1974; Warner, 2004) and the more recent critical, or “post”-psychiatry (Bracken & Thomas, 2010; Frances, 2013; Jureidini, 2012; Mosher & Boyle, 2004; Rudegeair, 2003; Treacher & Baruch, 1981). These critiques have

centred on the constructions of mental illness and the “unexplanations” (Jureidini, 2012) of psychiatry's primary classification tool the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)¹² (American Psychological Association, 2013), as well as the relationship, or alliance, between psychiatry and the commercial pharmaceutical companies (Breggin, 1993; Double, 2006; Frances, 2013; Healy, 2002; Kutchins & Kirk, 1997; Moncrieff, 2008; N. Rose, 2003; Whitaker, 2002).

However, these potential disruptions have appeared to have little effect in challenging the powerful, socially legitimated institution of biomedicine, as the plethora of journals inviting positivist scholarship indicates (Bonney & Stickley, 2008; Dutta & Zoller, 2008; Kecmanovic & Hadzi-Pavlovic, 2010; Koenig, 2000; Pincus et al., 1993). For this reason I foreground a critical gaze against a postmodern background, in search of a polyphony of voices (Broadfoot & Munshi, 2007), in order to more closely examine the dynamics that underpin the persistence of biomedical orthodoxy in mental health services. Below, I elaborate on the theoretical perspective that underpins this, and take a perspective on the socio-political and cultural stances towards “madness” that stand outside positivist scholarship, which has dominated the sense-making in biomedicine and psychiatry, and perpetuated inequitable and unjust social arrangements for people with experiences of serious psychological distress. This dominance has not only been ideological, hegemonic and embedded discursively in systems of social control, but has been at the expense of a plurality of voices, and has, therefore, created barriers to the establishment of alternative interpretations of experience.

The critical gaze on healthcare

Critical scholars, among them Foucault (1970, 1972, 1973), Deetz (1992) and Mumby (1988), have encouraged examinations of the social, political and historical processes through which wider social discourses have influenced and

¹² The *Diagnostic and Statistical Manual of Mental Disorders* is commonly referred to as the DSM. This provides the bases for all psychiatric diagnoses in the USA, New Zealand and Australia with the ICD [*Internationale Classification of Disorders*] being more commonly used in Europe.

penetrated contemporary institutions and social systems, including medicine and psychiatry (U'Ren, 1997), and created asymmetrical relationships of power among social groups. Unlike functionalists, who assume society to be well-functioning, benign and unified (Grob, 1991, 1994; Oliver, 1998, 1999; Parsons, 1975), critical scholars have regarded the barriers and problems of marginalised groups such as those with disabilities or “mental illness” explicitly as products of an unequal society (Oliver, 1998; Rappaport, 1984; N. Rose, 1998, 2006b; S. Rose, 1972; Turner, 1995; U'Ren, 1997). Thus, these scholars have regarded society as a perpetual struggle among more or less powerful groups competing for finite amounts of power and resources (Alvesson et al., 2008; Borch, 2005; Deetz, 1992; McCashen, 2005; Mumby, 1988; Rapp, Kisthardt, Gowdy, & Hansen, 1991; Rappaport, 1990; Zoller & Dutta, 2008).

A central distinction between a functionalist positivist perspective and a critical one, is the former's emphasis on social control and maintaining the *status quo*, which contrasts with a critical emphasis on social and organisational transformation that is intended to disrupt current distributions of power and resources (Foucault, 1970, 1972, 1980; Honneth, 2002; Oliver, 1998; N. Rose, 1999). Adopting a critical stance in organisational communication scholarship, therefore, has enabled examination of how organisational interests become structured, not only within organisations themselves, but also within the larger socio-political and cultural environment in which they are situated.

Unlike positivism, critical scholarship has intended to reveal what is rhetorical, or ideological and persuasive, in health literature (Babrow & Mattson, 2003). It has taken an overtly political approach; questioning the values of biomedicine and focusing on the identification of “political, economic, and historical factors that shape a culture's responses to and concepts of health, disease, and treatment issues” (Lupton, 1994, p. 58). Such approaches, for example, have treated the social impacts of mental disorder as ideological products of social inequity, which exclude people from society and restrict people's lives, as far more important than merely the symptoms of illness

(Bracken & Thomas, 1999; Carling, 1995; Oliver, 1998, 1999; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008).

In addition, a critical approach has been vital for understanding the issues of both institutional persistence and institutional change. Until recently, institutional theorists tended only to examine the mechanisms through which institutions, biomedicine and managerialism, for example, have remained stable, legitimate and authoritative throughout organisational fields over time (Barley & Tolbert, 1997; DiMaggio & Powell, 1983, 1991; Lawrence, Suddaby, & Leca, 2011; Meyer & Rowan, 1991). In contrast, critical scholarship has begun to attend to the challenges of institutional disruption and change, as well as the mechanisms through which institutions endeavour to contain change and react to perceived threats (Caronna, 2004; Colomy, 1998; Lounsbury, 2009; Maguire & Hardy, 2009; Mumby, 2008; Phillips, Lawrence, & Hardy, 2004; Reay & Hinings, 2005). These perspectives have addressed the struggles for voice of individuals, groups and organisations systemically disempowered by institutional logics; as well as the issues involved in attempting to introduce and establish credible, alternative rationalities and worldviews in both discourse and practice (Maguire & Hardy, 2009; Mumby, 1998, 2008; Reay & Hinings, 2005).

Both critical and postmodern approaches have been important foundations for this thesis (Deetz & Kersten, 1983; Dutta & Zoller, 2008; Ganesh, 2008). Mental healthcare has, historically, been peculiarly vulnerable to socio-political shifts and both these forms of inquiry have drawn attention to the blurred boundaries between organisations, wider societal norms and public dialogues (Mumby & Stohl, 1996, 2007) while providing platforms from which to challenge socially privileged interests and the distribution of power within social systems (Lord & Dufort, 1996; Lord et al., 2004; Pilgrim & Rogers, 1999; Rappaport, 1995, 2002). In addition, postmodern scholars have challenged the certainties of earlier eras; rejecting the idea that any group, or methodological approach, had a universal claim to “truth” (Foucault, 1970, 1972; Pilgrim & Rogers, 1999).

Critical scholarship and the postmodern turn: Making sense of power, inequity and social justice

Both critical and postmodern scholarship assume society, culture and organisations to be inextricably and reciprocally bound (Foucault, 1963, 1973; Warriner, 2010); underpinned by interacting sets of discourses and ideas that form the distinctive perspectives of social groups (Waitzkin, 1991). These scholars have explored the tensions between the “common sense” of the social world and the cultural and historical contexts that influence the establishment and maintenance of social orders and institutions such as healthcare, biomedicine and psychiatry (Foucault, 1970, 1972, 1973; Oliver, 1996, 1999; N. Rose 1998; N. Rose et al., 2006; Samson, 1995; Turner, 1995; U’Ren, 1997). For example, in *Madness and Civilisation*, Foucault (1973) was concerned to challenge the perspective of scientific reason about madness, which treated it as a constant, negative, objective fact. Instead, he and others claimed that specialised discourses such as biomedicine and psychiatry do not refer to “real” entities such as madness or mental illness; but, rather, that these concepts are socially constructed (Berger & Luckmann, 1967; Foucault, 1973; Jureidini, 2012; Leclercq-Vandelannoitte, 2011; Morrison, 2006; O’Hagan, 1994; John Read, 2004; N. Rose et al., 2006; Szasz, 1974).

Critical scholars, especially, have been interested in how culturally embedded ideologies, defined as a coherent set of shared social beliefs, have functioned to create social reality (S. Rose, 2000), concealing social contradictions, sustaining privileged interests and naturalising these in the “interests of all” (Alvesson et al., 2008; McNay, 1992; Mumby, 1988). These perspectives have been particularly useful in the field of health communication (Dutta, 2008). Critical studies of media, for example, have illustrated how ideologies of health and illness produce social knowledge that reflects dominant constructions and legitimise power relationships (Lupton, 1994), and also highlighted how media and communication strategies may resist or alter those power relationships (Ackroyd & Wyllie, 2002; Cutcliffe & Hannigan, 2001; Kline, 2006; Mental Health Commission, 1997; Nairn, Coverdale, S., & Coverdale, J.,

2011; Philo, 1996; Seale, 2004; Vaughan & Hansen, 2004). Together, critical and postmodern scholarship has been influential in turning away from reductionist constructions of health and illness to understanding the social production of knowledge and the distribution of social power (Dutta & Zoller, 2008; Pilgrim & Bentall, 1999; Pilgrim & Rogers, 1994, 1999; Zoller & Kline, 2008).

Postmodernists have shared with critical scholars a focus on the dynamics of power, the former being more concerned with dialectical tensions, specifically the mechanisms with which truth and power are intertwined and articulated. These scholars posit multiple, situated perspectives and “realities”, constructed through language and communication by groups engaged in struggles for control of the discourses within organisations and societies (Foucault, 1970, 1972; Ganesh, 2008). They assert that all “truths” mask, and/or serve, particular interests, and that the truths produced within a society have a normalising and regulatory function (Alvesson et al., 2008). Alongside critical theorists, postmodern scholars acknowledge that inequity is embedded in knowledge claims and are characteristic of the power of any group to determine meaning (Cheney, Christensen, Zorn, & Ganesh, 2004).

The postmodern turn positioned societies as fragmented and complex social structures in which discourses of social difference, such as gender, ethnicity, sexuality and disability, are apparent (Ashcraft & Pacanowsky, 1996; Ashforth & Mael, 2004, Oliver, 1998; Durie, 1999, 2001). These wider discourses have enabled scholars to explore how people and communities represent their experiences and how they develop social identities in relation to socially dominant or marginalised meaning systems (Dutta & Zoller, 2008; Ganesh, 2008). Their efforts have meant that postmodern sensibilities have been able to infiltrate, previously mainstream, critical concepts such as ideology, hegemony, praxis and the potential for social transformation (Deetz & Mumby, 1990; Mumby, 1988) which, in turn, has implications for exposing the ideological foundations of health discourses and undermining “normal” or legitimate ways of organising healthcare (Conrad & McIntush, 2003; Kendrick, 1997; Mumby, 1987, 1988; Scott, Ruef, Mendel, & Caronna, 2000).

Ideology and hegemony: Systems of control

In contemporary capitalist societies, managerial and professional perspectives, embedded in similarly functionalist and positivist medical and business schools, have assumed taken-for-granted status and become hegemonic (Ackroyd & Thompson, 1999; Hwang & Powell, 2009; Mizruchi & Fein, 1999; Mumby, 2005; Suddaby & Greenwood, 2001). Hegemonies serve to naturalise the asymmetry inherent in relationships and distributions of power. They create powerful elites and establish cultures that instil ideological practices and systems of belief (De Cock, 1998; Gramsci, 1971; Mumby, 1997). The concept of hegemony describes processes by which people “participate actively in the construction of the discursive systems and structures of their own subordination” (Mumby, 2005, p. 358). In particular, the biomedical model, positioned as authoritative, has naturalised the way healthcare, including mental healthcare is structured (Dutta & Zoller, 2008; Kecmanovic & Hadzi-Pavlovic, 2010; Moncrieff & Crawford, 2001; Pilgrim & Rogers, 1999).

A major concern for scholars has been the hegemonic equation of “taken for granted” common sense with acquiescence to dominant socio-cultural norms that limit people’s awareness of inequity and foster a sense of stability and inevitability without challenging, or changing, the material or structural circumstances of the social order (Alinsky, 1991; Deetz & Mumby, 1990; Freire, 1970; Gramsci, 1971). Under these conditions, subjugated groups frequently perceive their inferior status as natural and inevitable (Jermier, 1998; Mumby, 1988, 1997; U’Ren, 1997); meaning that wise resignation or “rational submission” (Comte, 1856) has been the naturalised response to structural and systemic inequity in society (Jermier, 1998).

Foucault (1970, 1972, 1973) was especially concerned with the naturalised rationality, or scientific reason, of the psychiatric perspective, the role of professional power and “governmentality” (N. Rose, 1998) in constituting, classifying and regulating madness in society. He argued that these enabled social controls to be established unobtrusively, without overt use of coercion or conflict (Jermier, 1998). In addition, and historically, bureaucratic organisational

forms became social tools that centralised and legitimised power and control over the many, by a privileged few, while simultaneously disguising that centralisation (Jermier, 1998; Perrow, 1986). This was significant because overt exercises of power tended to sit uneasily alongside ideologies of democratic governance and a free market that promoted basic capitalist values of individual freedoms, economic growth and the accumulation of wealth and its privileges (Jermier, 1998; Perrow, 1986). This has had important implications, over time, for the organising of Western mental health systems, which have been especially vulnerable to bureaucratic and institutional administrative power (Foucault, 1963, 1976; Johns, 2010; Lammers et al., 2003; Pilgrim & Rogers, 1999; U'Ren, 1998).

Anchoring these systems of control have been the language and meaning systems in which knowledge, concepts and beliefs have been conceived and communicated. The linguistic turn in social scholarship (Alvesson & Kärreman, 2000; Deetz & Mumby, 1990; Fairclough, 1992; Foucault, 1972; Mumby, 1988; Mumby & Stohl, 1991; Reed, 1998) has similarly acknowledged the role of language in the management of knowledge claims; how these come to be naturalised and, in turn, have demarcated the boundaries between privileged and marginalised groups such as medical professionals and “mental patients” (Fee, 1999; Nairn, 1999; O'Reilly & Reed, 2011; Waitzkin, 1989, 1991; Weeks, 1996).

Language, communication and discourse: The constructions of “madness”

Discourses are inherent aspects of sociocultural practices: embedded in their contexts, culturally conditioned and socially constitutive (Fairclough, 1997; Cheney et al., 2004). Critical and postmodern scholars have maintained that systemically embedded practices of language, that are validated by a particular community or discourse do not merely identify objects, but actively constitute and legitimate the objects of which they speak (Foucault, 1972; De Cock, 1998). However, not only have these constructive processes been obscured and naturalised within social groups, organisations, communities and societies (Berger & Luckmann, 1967; Foucault, 1972; Gergen, 2001), but discourse has

become real to the extent that it “participates in the development, enactment and reproduction of material practices” (Holmer-Nadesan, 1996, p. 52).

Foucault (1972, 1980), in particular, focussed on how the legitimacy of knowledge has been constituted for a particular group or society; where the discourses that have created meaning systems and shaped social realities have excluded other perspectives as *ir*-rational, *un*-natural and alternative to the dominant orthodoxy (Fairclough, 1992, 1993; Fee, 1999; Foucault, 1972, 1980). Thus, social legitimacy, enclosed in discourse, has deflected, or excluded, other paradigmatic perspectives by being effectively blind to concepts outside the boundaries of the dominant worldview (Deetz, 1992; Lakoff & Johnson, 1980).

Such normalised discourses have enabled the power inherent in legitimating institutions, such as the medical profession, to persist by defining the language and practices that allow professional and powerful groups to advance particular arguments and knowledge claims. For example, Foucault (1963, 1973) contended that the separation of reason and unreason became complete through psychiatric language that defined its own terms, categories and identities e.g. the patient identity that diminished personhood and contrasted the professional, expert identity (Bracken & Thomas, 2001; Grob, 2004; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997; Saleeby, 2001). He described a scientific “monologue of reason about madness” (Bracken & Thomas, 2005, p. 2) that reconstructed subjective experiences as social failure and then subjected them to *reasoned* care and treatment. Unfortunately, such *reasonable* practices systematically depersonalised, stigmatised and diminished a person’s sense of valued identity and personal power (Anthony, 1993; O’Hagan, 1994). This has meant that the routine use of the DSM in orthodox biopsychiatry, despite being severely criticised as seriously flawed and lacking in construct validity (Kirk & Kutchins, 1992, 1994; Kutchins & Kirk, 1997; Duncan et al., 2004), has remained authoritative in orienting the discourses about mental “illnesses” and their treatments (Bracken & Thomas, 2001; Grob, 2004; Jureidini, 2012; John Read et al., 2004; Saleeby, 2001).

However, discursive fields (Foucault, 1972), including psychiatry, inevitably contain a number of competing discourses and subject positions to give meaning to, and organise, social institutions and processes. Although no single discourse exhausts the meaning of concepts and practices, discourses often act in conjunction. Biomedical and legal discourses, for example, construct madness from distinct perspectives, yet they share regularities, or sets of rules, that reinforce each institution and their relationships with each other. Similarly, the discourses of patriarchy and capitalism, science and capitalism (Ganesh, 2005; Holmer-Nadesan, 1996) and biomedicine and capitalism (Frances, 2013; Healy, 2002; Mosher, 2004; U'Ren, 1997) have also reinforced each other through shared paradigmatic and ideological bases such as individualism, functionalist rationality and notions of expertise (Broadfoot & Munshi, 2007; Cooren 2004; Foucault, 1973, 1980; Oliver, 1998; U'Ren, 1997).

Critical communicative approaches have exposed on-going struggles between multiple interest groups for the power to define, construct and challenge organisational realities such as organisational identity, values and the nature of organisational outcomes (Deetz & Mumby, 1990; Fairhurst & Putnam, 2004; Mumby, 2008). Drawing from Foucault (1970, 1972), other researchers have been interested in how institutionally powerful groups accumulated and safeguarded their interests. They conclude, for example, that the capacity to define the terms of a discourse also determined who might legitimately participate, whose voices were heard, or ignored while simultaneously controlling access to specialised knowledge and information (Cheney et al., 2004; Deetz, 1992; Mumby & Stohl, 1996, 2007). Social order, therefore, is determined by the groups that prevail in the discursive struggle.

So saying, discursive fields also offered alternative modes of subjectivity (Weedon, 1987) and thereby created sites of potential resistance (Mumby, 2005) and new spaces for social action and change (Holmer-Nadesan, 1996; Trethewey, 1997). Critical and postmodern scholarship, therefore, has challenged elite definitions of social issues and engaged in struggles for legitimate representation of the exploited and oppressed (Freire, 1970; Horkheimer, 1972). Critical and

postmodern scholars have also sought to privilege the voices and perspectives of marginalised groups (Dutta & Zoller, 2008; Horkheimer, 1972) in order to allow these groups to define their own experience and create legitimate, subjective identities (Chamberlin, 1988; Gillespie, 2001; Morrison, 2006). Ackroyd and Thompson (1999), for example, contended that a critical lens addresses "the removal of workers from the academic gaze" (p. 161) and counters the managerial perspectives dominant in organisational studies and business schools (Ackroyd & Thompson, 1999; Babrow & Mattson, 2003; Hwang & Powell, 2009; Mizruchi & Fein, 1999; Mumby, 2005; Suddaby & Greenwood, 2001). By working to disrupt dominant, closed systems of meaning these scholars have sought to provide possibilities for social action and organisational transformation (Dutta & Zoller, 2008).

Imagining alternative ways of organising and investigating possibilities for transformation

Critical and postmodern scholarship in healthcare has moved beyond critiques of social relations (Waitzkin 1991) with the intention of uniting theory with social change (Alvesson et al., 2008). As Dennis Mumby (1988) has argued, "Critical theory is far less interested in predicting the future than in making it" (p. 104). It has also been important not merely to address isolated instances of inequity but to recognise, challenge and ultimately break mutually reinforcing systems of social injustice (Broadfoot & Munshi, 2007a; Horkheimer, 1972; Jermier, 1998). New, or alternative, discourses, such as recovery have offered sites where hegemonic practices can be contested, challenged and resisted (Freire, 1970; O'Hagan, 2004; Maguire & Hardy, 2009; Mumby, 2008; Ramon, Healy, & Renouf, 2007).

However, inevitably, emerging perspectives engage with, and are constructed with reference to, the social contexts and dominant discourses that already exist. This has meant that being framed as *alternative* has generally been accompanied by a corresponding lack of credibility, legitimacy and power to effect change. Social change efforts for marginalised groups within hegemonic social systems, therefore, have been especially fraught. In the

mental health field, disrupting the social legitimacy of the biomedical paradigm has been especially problematic because discourses of madness have, historically, been more socio-culturally and ideo-politically constructed than physical disability or illness (Barker, 2003; Kecmanovic & Hadzi-Pavlovic, 2010; O'Hagan, 2004, 2009; S. Rose, 2000; Wallcraft, 2009). The first issue has been the relative invisibility of the mechanisms by which hegemonies are sustained. It has been difficult for marginalised groups even to envisage social change let alone imagining how to effect it (Freire, 1970).

The second issue, for advocates of social change, has been the difficulty in finding allies who are not compromised, or challenged, by that prospective change. For example, delivering “quality” mental health care as a social service has inevitably confronted the commercial imperative to purchase the cheapest goods and services (Czarniawska-Joerges, 1988, 1995; Eisenberg, 1984; Zorn et al., 2011, and others). Similarly societal mistrust of *difference* has routinely overridden the human rights of users of mental health services; while their subjective expertise has been undermined by hegemonic and hierarchical systems of medical power and professional expertise (Anspach, 1979; Cresswell, 2009; Everett, 1994; Morrison, 2006; Oliver, 1998; Tilly, 1996).

Conclusion

In conclusion, critical and postmodern scholarship has particular significance for all fields of health and mental healthcare where a positivist, biomedical model is dominant (Bracken & Thomas, 1999; Kecmanovic & Hadzi-Pavlovic, 2010; Pilgrim, 2007; Pilgrim & Rogers, 2003; John Read, 2005). For marginalised groups, such as the “mentally ill”, who have typically been both voiceless and powerless about their experiences and the terms of their “containment” in mental health services, critical and postmodern approaches have provided critiques of the status quo alongside a desire for action and social transformation.

These critical and postmodern perspectives provide a rationale for utilising the framework of problematics for organisational communication

research developed by Mumby and Stohl (1996, 2007). The framework structures the critical review of the literature that follows, which addresses the issues from which my research questions arise. In the next chapter, therefore, I utilise this framework to critically examine the wide range of external influences, social norms and dominant rationalities that have impacted on the evolution of Aotearoa\New Zealand mental health organisations. I also use the literature to analyse some tensions and challenges that community organisations face in endeavouring to adopt a recovery orientation in their organisational practices within the context of powerful institutional discourses such as biomedicine and managerialism.

Chapter 4: Literature review

Introduction

The previous chapters established three warrants for this review of the literature. First, over the last sixty years mental health systems and organisations have been undergoing significant reform internationally. The progress of this reform has been influenced, and sometimes constrained, by a complex inter-relationship of contributory factors, all of which have impacted on the everyday practices and organisational realities of the community organisations. These factors have included the introduction of a recovery philosophy that has worked in conjunction with growing civil rights movements; but remained in tension with biomedical psychiatry and managerialist intrusions into healthcare (Adame, 2006; Anspach, 1979; Cresswell, 2009; Everett, 1994; Morrill, Zald, & Rao, 2003; Morrison, 2006). This creates the foundation for my first research question, which asks: In what ways are discourses of recovery constructed, negotiated and resisted in everyday practice within non-government community mental health organisations in Aotearoa\New Zealand?

Second, constructions of mental illness and its treatments have largely been institutionalised by biomedicine and naturalised by the hegemonic status of the “scientific method” in Western societies. Within this framework, the lived experience of people diagnosed with mental illness, and their own sense-making, has been systematically devalued and dismissed (Deegan, 1988; Leibrich, 1998; O’Hagan, 1994; John Read et al., 2004). However, alternative explanatory models, treatment responses and strategies for recovery have begun to be elaborated; grounded in the narrative accounts of people with lived experience of psychological distress (Jacobson & Greenley, 2001; Leibrich, 2000; O’Hagan, 1998, 2004; Ridgeway, 2001). From this context, I address my second research question: How are institutional dynamics working to construct, constrain or contradict organisational practices in terms of becoming recovery-oriented?

Third, a philosophy of recovery, introduced as formal policy in Aotearoa\New Zealand mental health services over a decade ago, has

represented ways of constructing the subjective, human experience of serious psychological distress that have directly challenged the prevailing orthodoxy of biomedicine and the reification of mental illnesses. However, it is by no means certain that this discourse has effectively disrupted the institutional structures and practices of biomedicine and managerialism in the organisation of mental health care in this country. Therefore, my third research question asks: In what ways are institutional dynamics being problematised and challenged within the community NGOs and to what effect?

Given these questions, this review explores literature that has documented and underpinned the discourses of mental health, mental illness and recovery in contemporary Aotearoa\New Zealand mental health organisations. In doing so, it considers the contexts and socio-political circumstances in which recovery has been constructed, negotiated and resisted within the mental health sector, and which have shaped organisational practices and communications, particularly in the community NGOs. The approach sets the stage for detailed discussion of studies in communication, health and organising, which inform an analysis of what constitutes effective organisational practices within the community mental health sector in Aotearoa\New Zealand. Similarly, examination of this literature underpins the stated objective of this thesis (p. 5); in other words, the ways that these organisations are fulfilling expectations of becoming recovery-oriented.

I structure this discussion in terms of the four problematics for critical organisation communication scholarship outlined by Mumby and Stohl (1996, 2007): (1) The problematic of rationality, (2) the problematic for organising and society, (3) the problematic of organising, and (4) the problematic of voice. This framework enables me to consolidate various critiques of institutional, and other, rationalities and discourses that have influenced contemporary organisation of the mental health sector in Aotearoa\New Zealand. In doing so, I further highlight the significance of my research questions and rationalise the design and methodology of the project.

The first problematic of rationality is critically concerned with what seems *reasonable* within the paradigmatic, social and historical circumstances from which it arises. In other words, what may be logically coherent in a social system is necessarily inextricable from the discourses and practices that have shaped that social reality and will inevitably be self-referential (Broadfoot & Munshi, 2007a; Knights & Morgan, 1991; Mumby & Stohl, 1996, 2007). The second problematic is concerned explicitly with the relationship between organisations and societies. In particular it focuses on the social, political and ideological production of knowledge and how this influences organisational forms, discourses and practices. The third problematic attends directly to the configuration of the mental health sector and the ways that institutional features influence the communication of discourses and ideas across organisational boundaries that in turn govern everyday organisational practices. The problematic of voice in critical and postmodern scholarship has been focussed on who speaks and who is listened to within organisational and social systems. This raises issues of identity, marginalisation and naturalised rules about who can legitimately construct organisational and social knowledge.

The problematic of rationality in mental health and psychiatry

Foucault (1973) observed that a scientific discourse, like any other, is a community practice (Calsamiglia, 2003). In other words, scientific rationality is no more than a set of metaphors and narrative conventions around which ideas of reality and truth are contrived. These, then, guide the interpretation of experience towards particular outcomes. Therefore, in this section, I explicitly examine the problematic of rationality (Broadfoot & Munshi, 2007; Mumby & Stohl, 1996, 2007) in Western mental health systems, and specifically the nature, power and reach of the rationalities that underpin both biomedical and recovery discourses, as these are applied in Aotearoa\New Zealand mental health organisations. First, I outline the key principles of the positivist or reductionist scientific method and the effect this has on the legitimacy of knowledge and the nature of evidence. I then examine the implications this rationality has for the development of treatments and the ways that outcomes are defined and

measured in Western mental health systems. I then critique these ways of thinking and knowing about the world with respect to alternative explanatory models, specifically recovery, and the significance of these tensions for people with lived experience of serious psychological distress. I conclude with a discussion of what people themselves say are effective supports and the limitations of technological solutions.

The rationality of Western science and the scientific effect

In the Background chapter, I discussed the influence of positivism on the growth of medical knowledge in Western mental health systems. Here I investigate how that has paralleled the increasing dominance of a *scientific* rationality as the authoritative source of legitimate knowledge in Western societies at large (Alderson, 1998; Canguilhem et al., 1989; Foucault, 1970; Thomas et al., 2005). In particular, the techno-scientific framework has purported to render human consciousness and behaviour understandable through a scientific vocabulary and world-view that accounts for the world “as it really is” (Bracken, & Thomas, 1999, 2001).

Increasingly, therefore, human experience has come to be regarded as the rightful concern of psychological experts and scientific psychiatry, and human agency has been reduced to mere compliance with expert direction (Bracken & Thomas, 1999; Oliver, 1998). Psychiatry's promise to control madness through medical science, therefore, has resonated with social acceptance of “scientific” explanatory models to the extent that academic psychiatrists Patrick Bracken and Philip Thomas have commented that “it is now almost heretical to question this paradigm” (Bracken & Thomas, 2001, p. 725).

The rationality of the scientific method is construed as a series of principles that constitute, reflect and express reality as stable pre-existing patterns logically connected to general laws. Naturalisation of this rationality has valorised objectivity, prediction and control over subjective meaning and experience (Bracken & Thomas, 1999) and infused the social imagination with a type of scientific determinism that has conditioned people to the inevitability of

techno-scientific advance as the “natural” order of human progress (Postman, 1993; N. Rose & Miller, 2008; Swingewood, 2000). Knowledge generated by this epistemology is assumed to evolve as more and more of this reality is “discovered” by scientific observation and measurement (Knights & Morgan, 1991; Mumby & Stohl, 1991). However, the credibility of a techno-scientific paradigm in the realm of human activity ultimately depends on its “adequacy in describing experience; its ability to explain experience, and its potential to transform experience” (Oliver, 1998, p. 163).

In adopting a techno-scientific biomedical model, psychiatrists exchanged subjective, social and experiential understandings of human distress with the assumptions of Cartesian dualism and a Newtonian metaphor of the body as machine (W. Brunton, 2001; Nettleton, 1995). They embarked, therefore, on a quest for the identification and measurement of supposedly “universal” symptoms or behaviours. They assumed that using statistical models and epidemiological populations would eventually, and inevitably, lead to general laws and “absolute truths” about the causes, diagnoses and prognoses of mental illnesses (Canguilhem et al., 1989; Foucault, 1963, 1970; Guze, 1989; Kuhn, 1970; Nelson et al., 1987; Thomas et al., 2005). The production of these “truths”, including the recent surge to evidence-based practices in medicine and psychiatry (Jacobson & Greenley, 2001; Oliver, 1998), has so thoroughly pervaded Western cultures that claims of “clinically proven” and “scientifically tested” have been used to promote everything from toothpaste to shoe design.

Intriguingly, psychiatry has never really existed comfortably within a generic scientific model and despite adherence to a positivist rationality, many bio-psychiatric hypotheses and treatments have been subsequently discredited; as well as many practices that would be considered repellent in contemporary societies (Bracken & Thomas, 1999, 2001; Kirk & Kutchins, 1992; Moncrieff & Crawford, 2001; Pilgrim & Rogers, 2009; Samson, 1995; Szasz, 1960). Perhaps the most substantial consequence of the biomedical model in psychiatry has been the reification of mental illnesses, and its major accomplishment the diagnostic classification system DSM; in which clusters of observable symptoms

have been arranged into pre-determined categories from which diagnosis is made and “appropriate” physical treatment prescribed (Aldhous, 2009; American Psychological Association, 2013; Frances, 2013; Kendell & Zabransky, 2003; Kirk & Kutchins, 1992, 1994). However, as Thomas Szasz (1960) noted, there is a significant conceptual distinction between a disease of the *mind* and a disease of the *brain* (Szasz, 1960). He famously described psychiatric diagnosis as a “covert comparison of a person's own ideas, concepts, or beliefs with those of the observer and the society in which they live” p. 114). This suggests that scientific psychiatry, far from having legitimate claims to privileged truths where new discoveries are built on previous theory, has been as much a product of its socio-normative, political and cultural environment as it is of empirical rationality (Broadfoot & Munshi, 2007a; Mumby & Stohl, 1996, 2007).

Scientific conventions have provided psychiatric orthodoxy with its language, vocabulary and self-referential systems of academic scholarship (van Dijk, 1993, 2001). Alternative perspectives, unfortunately, appear to have done little to challenge the predominant biological paradigm (Moncrieff & Crawford, 2001). Moncrieff and Crawford (2001), in their comprehensive review of the *British Journal of Psychiatry* throughout the 20th century, concluded that there have been no major shifts in the explanatory paradigms utilised by psychiatry, and the emphasis on biological psychiatry, in fact, is a continuation of a long-standing inclination. They maintained that the disproportionate attention paid to clinical neuroscience has meant a paucity of academic scholarship that deals with the human aspects of therapeutic encounters in the field of mental health (Bracken & Thomas, 1998). Their review supported earlier findings (Grob, 1983; Moncrieff & Crawford, 2001; Pincus et al., 1993; Scull, 1979).

However, unlike physical medicine, psychiatric symptoms do not have determinate signs (Jureidini, 2012; John Read et al., 2004) and rely on interpretations of the boundaries between “normal” and *ab-normal* human functioning; they do not specify unique disorders or disease. Szasz (1960), and those that followed him, argued that treating “complex psychosocial behaviour, consisting of communications about ourselves and the world about us, as mere

symptoms” (p. 114) was an epistemological flaw; not merely an error in observation or reasoning, but a fault in how knowledge is framed, organised and expressed (Szasz, 1960, 1974; Foucault, 1963, 1973; Pilgrim, 2007; Read et al., 2004).

In addition, the naturalised positioning of biomedicine as a higher order of discourse (Foucault, 1970, 1972) created discursive closure around other, “lower order” kinds of evidence such as subjective experience (Deetz, 1992; Foucault, 1970, 1972). This made it easier to reference notions of *scientific scrutiny* and *demonstrated effectiveness* without further clarification or explanation (Torrey et al., 2005). This chain of linguistic reasoning has also enabled clinical professionals to normalise symptom control as the only valid measure of treatment outcome. In the next section, I extend this discussion of scientific rationality to frame recent concerns about the emphasis on evidence-based practices that has grown alongside technological advances in all areas of medicine, including psychiatry (Anthony, 2003; Anthony et al., 2003; Salyers & Macy, 2005; Torrey et al., 2005).

Evidence based practice: The nature of evidence, treatment and outcomes

Evidence based practice has been optimistically defined as “the integration of best researched evidence and clinical expertise with patient values” (Institute of Medicine, 2001, p. 147). However, many scholars have warned that simply measuring that which readily lends itself to measurement, has grossly oversimplified the extremely complex nature of psychological distress and therapeutic responses (Bracken & Thomas, 1999, 2001; Greenhalgh, 1999; Pilgrim & Rogers, 2009; John Read et al., 2004). Other commentators have protested the application of statistical and population based modelling to experiences that are ultimately subjective, such as therapeutic relationships and psychosocial interventions (Bracken & Thomas, 1998; Duncan et al., 2004; Hubble et al., 1999). In addition, narrow, quantitative definitions of what constitutes *valid* evidence have tended to support treatments in medicine and psychiatry that have been research funded and subjected to random controlled

trials (RCTs) (Bracken & Thomas, 1998, 2001; Duncan et al., 2004; Torrey et al., 2005).

However, as Mark Hubble and his colleagues (1999) warned, more than 50 years of “increasingly sophisticated outcomes research” (Hubble et al., 1999, p. 435) has produced little empirical support for the efficacy of psychiatric diagnoses in determining appropriate treatment regimens. Nor has it demonstrated the superiority of medications over other forms of treatment (Hubble et al., 1999; N. Rose, 2003). In addition, many scholars have questioned the validity and the ethical, as well as ideological, bases for commissioning of some of these studies; including the commercial interests of the pharmaceutical giants (Chalmers, 2001; Duncan et al., 2004; Frances, 2013; Healy, 2002; Kutchins & Kirk, 1997; Moncrieff, 2007, 2008).

Unfortunately, the narrow focus of the evidence-based approach has generated a body of knowledge that has excluded the wider social and subjective factors that influence a person’s individual experience of treatment responses. Scholars have noted that, as evidence-based practices (EBP) have been developed, described and replicated (Torrey et al., 2005), important philosophical elements and the values of a practice, as well as the person’s own explanatory system, have been routinely omitted. These elements have been dismissed because they are not empirically linked to traditional outcomes such as reduced symptomology, reduced hospitalisation, or improved employment rates (Drake et al., 2001). However, critics have argued that EBP has focussed on particular treatments as if they are isolated from the most powerful factors that contribute to change, i.e. the person’s own resources, perceptions and participation (Anthony, 2003; Duncan et al., 2004; Salyers & Macy, 2005). Others have gone as far as to assert that “evidence based practice is the empirically bankrupt notion that for a particular problem, there is a specific treatment that is best” (Duncan et al., 2004, p. 38).

Current evidence based research has, therefore, not acknowledged or been engaged with the rich and insightful learning that can be gleaned from qualitative and subjective approaches (Anthony et al., 2003). Typically, it has

been conceived without reference to the experience of people with lived experience of serious psychological distress, or the emergence of the recovery concept (Anthony et al., 2003). Consequently, there have been few conscientious attempts to explicate how recovery values might be translated into specific service dimensions (Farkas et al., 2005).

Furthermore, “scientific” evidence-based research does not capture the subjective, interpersonal and environmental factors that significantly affect a person’s experience of treatment, services and the process of their recovery (Anthony, 2001; Anthony et al., 2003; Farkas et al., 2005). This has led Anthony (1993), among others, to claim that:

Recovery as a concept is by no means fully understood. Much research, both qualitative and quantitative, still needs to be done. Paramount to the recovery concept were the attempts to understand the experience of recovery from mental illness from those who are experiencing it themselves. Qualitative research would seem particularly important in this regard (p. 533).

Similarly, critics have suggested that evidence-based research has contributed little to understanding recovery outcomes, identified by people with lived experience of psychological distress, as being meaningful or useful in their lives (Chadwick, 2002; Farkas et al., 2005; Frese et al., 2001; Salyers & Macy, 2005). Although most clinical practitioners would acknowledge that interventions, indicative of recovery for one person, may be different for another (Deegan, 1988; Spaniol, Koehler, & Hutchinson, 1994), commentators have criticised the claims of the *DSM* to precisely define disorders that have encouraged clinicians to mandate the treatments people receive and the level to which these are funded (Double, 2002; Carson, 1997; Chalmers, 2001; Hubble et al., 1999; Kirk & Kutchins, 1992, 1994).

Effective treatment and the limitations of technical solutions

Measurement of psychological distress, as well as treatment efficacy, has been problematic because of the ill-defined but universal assumption of a baseline “normal” to which all aspects of human psychology, emotional states and behaviour can supposedly be referred (Canguilhem et al., 1989; Duncan et al., 2004; Hubble et al., 1999; Kirk & Kutchins, 1994b; Kutchins & Kirk, 1997; Zoller & Kline, 2008). Critics have claimed that the underlying functionalist ideology of biomedicine, in valorising efficiency and conformity, has produced a professional imperative to maintain the “normal” functioning of individuals and society (Canguilhem et al., 1989; Foucault, 1973; Oliver, 1999; Wolfensberger, 1980). In addition, commentators have noted that limiting treatment responses to purely scientific measurement has inevitably excluded a range of healing experiences from examination and research. This has resulted in a tautological situation whereby therapies not “proved” successful have consequently not been funded (Leibrich, 1998; O’Hagan, 2001).

The pursuit of targeted, physical treatments that correspond with increasing specificity to the systematic classification of mental disorders (Bracken & Thomas, 2001; Jureidini, 2012; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997) has generated a long and horrific history of treatments that have included various forms of physical restraint, systemic shocks including electro-convulsive therapy, psycho surgery (e.g. lobotomy) and, of course, a variety of psycho-active chemicals or medications (Bracken & Thomas, 2001; Grob, 2004; Melling, 1999; Porter, 1991; Pearson, 2000; Samson, 1995; Scull, 1979). Increasingly, critics have voiced scepticism about medications being advanced as “magic bullets” (Frances, 2013; Kamens, 2011; Kirk & Kutchins, 1994b; Spitzer, 1999), and more than one psychiatrist has commented that “if we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised” (John Read, 2005, p. 3).

Considerable unease about the commercial interests of the pharmaceutical industry has been accompanied by criticisms, from within psychiatry, that neuroleptic medications do little more than control behaviour by

suppressing responsivity and levelling mood (Chalmers, 2001; Frances, 2013; Moncrieff, 2007, 2008). Scholars who have undertaken research with broader parameters have seriously questioned these purely techno-scientific responses. For example, Mark Hubble and his colleagues (1999) found that the quality of the therapeutic relationship, irrespective of treatment modality, was the most predictive of beneficial outcomes. Similarly, psychiatrist Jon Jureidini declared that “if the benefits of the therapeutic relationship between prescriber and patient are ignored, most drugs do little more than take the edge off suffering” (Jureidini, 2012, p. 190). He argued that this was equivalent to saying that an anaesthetic could cure a broken leg.

Clinical outcomes, characterised by symptom reduction and behaviour control, have therefore been in tension with outcome measures that are subjectively meaningful to people with lived experience of serious psychological distress (Anthony, 1993; Banks et al., 2004; Davidson et al., 2007; Deegan, 1988; Lapsley, 2004; Lapsley & Nikora, 2002; Lehman, 2000; Mental Health Commission, 2011b; Onken et al., 2000). Academic psychiatrists Pat Bracken and Philip Thomas (1999) have argued that many professionals have failed to engage with mental health service users as “full human beings who have lives as well as symptoms” (p. 11).

Other critical and postmodern scholars have maintained that the scientific stance has produced impoverished notions of human knowledge, community and the possibilities for social transformation (Mumby, 1988; Habermas, 1987). These scholars have warned against privileging technical forms of rationality over practical and emancipatory reality (Broadfoot & Munshi, 2007a; Mumby, 2008); instead, they have championed multiple ways of coming to “know” that are dynamic, situated and contextualised (Bracken & Thomas, 2005; Eisenberg, Murphy, Sutcliffe, Wears, Schenkel, 2005; Fee, 1999; Ganesh, 2008).

Alternative explanatory models and the nature of outcomes

Foucault (1973), in examining the social conditions that made the field of psychiatry possible, concluded that the great confinement of the mad was neither the necessary nor inevitable consequence of the growth of “truth” or knowledge; nor did madness represent a “flagrant contempt for logic and systematic thought” (Turner, 1995, p. 56). Nevertheless, the evolution of the field has had many disturbing implications, and presented real difficulties, for vulnerable people.

First, biomedical psychiatry has not been able to identify, or measure, indicators of distress directly or objectively. Instead, a person’s state of mind has only ever been inferred through observations of their behaviour and talk, filtered through the psychiatrist’s own scientific lens. Second, critical commentators have noted that the predominant focus of psychiatric training and practice has been on pain and functioning at the expense of relationship and meaning. They have argued that, in so doing, the profession has risked “providing analgesia at the expense of understanding” (Jureidini, 2012, p. 190).

Although many have argued that there is a “lack of knowledge about the interventions and services that will help people recover from severe mental illnesses” (Farkas et al., 2005), mental health service development has remained heavily influenced by assumptions that people do not recover. Commentators agree that recovery is conceptually difficult to measure; but have argued it is possible to describe significant aspects of, and provide evidence for, what is efficacious for a particular person in terms of reclaiming a meaningful, purposeful life in the settings of their choice (Mental Health Commission, 2011b; Onken, Dumont, Ridgway, Dorman, & Ralph, 2000; Perkins, 1999; Turner-Crowson & Wallcraft, 2002). These scholars have advocated for qualitative measures of recovery values, such as opportunities for successful living and positive engagement with their communities of choice; rather than conventional systems of treatment outcomes concerned with stability, functional maintenance and behavioural control (Banks et al., 2004; Barber, 2005; *Central Potential*, 2008; Warriner, 2001).

Recovery, and related approaches such as strengths-based practices, has always been more concerned with human flourishing than symptom control (Barber, 2005; McCashen, 2005; Rapp, 1998; Saleeby, 2001, 2002). Generic accounts of successful recovery outcomes by those with experiences of distress have invariably referred to a renewed sense of identity, self-determination and the right to live an ordinary life in community with equitable access to resources and opportunities. Unfortunately, the various attempts to measure recovery (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005) have had little impact on the design and delivery of mental health services; unlike clinical measures such as *Health of the Nations Outcome Scale* (HONOS¹³) (Royal College of Psychiatrists, 2010). This has led service users and others, including the community NGOs to call for expanded notions of mental health service outcomes to include dimensions such as quality of life, self-esteem, empowerment, satisfaction, and well-being (Anthony, 2003; Bond et al., 2001; Bonney & Stickley, 2008; Salyers & Macy, 2005).

Despite being ignored by many practitioners (Slade, 2009) service user conceptualisations of recovery outcomes have inevitably challenged the fundamental rationality and drivers of the mental health system such as the reification of mental illness, a deficits framework and the notion of force and compulsion in treatment (Kisely, Smith, Preston, & Xiao, 2005; Minkowitz, 2006; O'Hagan, 2008, 2009; Slade, 2009). Service users and others have also objected to the serious, harmful and long-term effects of powerful psychotropic drugs (O'Hagan, 1994; Leibrich, 1997; Moncrieff, 2007, 2008; N. Rose, 2003), especially where the effectiveness of these medications is doubtful and the long-term damage so unclear (Breggin, 1993; Healy, 2002; Moncrieff, 2007, 2008; Mosher, 1999; Mosher & Vallone, 1995; N. Rose, 2003; Whitaker, 2004). Many critics have protested that little research has been undertaken, or funded, to attend to these effects or to user views in general (Fisher & Greenburg, 1997; Healy, 2002;

¹³ HONOS is the Health of the Nation Outcomes Scale promoted by Te Pou as a universal national measure of service outcomes. This tool is necessarily administered by a 'clinician' further increasing clinical involvement in NGOs

Whitaker, 2004). Service user accounts of services, where these are gathered at all, have typically been used to measure the success or otherwise of a service, rather than inform meaningful change in a person's own well-being or social circumstances (Bell & Lindley, 2005; Kendrick, 2012; Kendrick, Petty, Bezanson, & Jones, 2006; Kent & John Read, 1998; Lord et al., 1998; O'Brien & Sullivan, 2005; S. Rose, 2000).

These issues suggest that an alternative rationality, or explanatory model, of recovery has done little to disrupt the positivist, techno-scientific rationality that has dominated the construction of what counts as valid knowledge in mental healthcare. This circumstance has significant implications for people, who have experienced serious psychological distress, and the conduct of their lives within their communities. In the section that follows, I discuss further the implications of the normalisation of biomedical science and its relationships within Western societies and other socio-political institutions. In particular, I attend to the powerful effects that constructions of mental health and mental illness have in constituting social norms and the relationships between powerful groups, such as health professionals, and others who are marginalised and comparatively powerless within a social system.

The problematic of the relationship between mental health organisations and society

As a rule, societies have willingly and with some relief, surrendered the authority for explaining and responding to the unintelligible and frightening in their midst, to the social institutions of their time, and have typically been the church, the law and the medical profession (Pilgrim & Rogers, 1999; Pearson, 2000). This has meant that the arrangements of institutions and organisations established to treat and contain those who have "lost" their reason have inevitably reflected the interests of wider, contemporary society and the bias of contemporary societal norms. Systems of care, therefore, have tended to be focussed on the "normalisation" of difference and deviance (H. Brown & Smith, 1992; Canguilhem et al., 1989; Oliver, 1998b; Pilgrim & Rogers, 1999). These issues are especially important for addressing my second and third research

questions because they underpin an understanding of how social and institutional norms become embedded, and powerful, in discourse and practice thereby governing organisational forms and the relationships among them.

In this section, I expand the earlier discussion, and scholarly scrutiny, of the close relationship between power and the social production of knowledge in order to attend to the societal organisation of healthcare and its relationship to the state. In particular, I shift the focus to the political and ideological structures that underpin the organisation of mental health care in Western societies. First, I examine political economies, specifically capitalism in Western societies, and show how their ideological bases create hegemonic positions of power and privilege within society that, in turn, define and normalise particular notions of health. I then look at how professional identities and alliances maintain and reproduce power, privilege and the social status of dominant groups. Inevitably, this discussion leads to the ways that some groups, such as those with experience of serious psychological distress, become marginalised and powerless. I then critically examine the roles of social norms and social policy in constructing and maintaining notions of normality and deviance that have led to stigma, discrimination and social exclusion for vulnerable groups such as those diagnosed with mental illness. Finally, I attend to scholarly concerns about individualism, and the focus on personal responsibility, which in healthcare has been a cornerstone of ensuring the continuing legitimacy of the status quo.

Capitalism and the commodification of health

Political economies establish the junctions and interactions among governments, economic systems and the status of groups within society (Ashton, 1999; Frumkin & Andre-Clark, 2000; Oliver, 1999; U'Ren, 1997). These relationships have enormous influence, structuring the lives of individuals, groups and communities and effectively become a “closed universe of meaning, tied to social structures as organised patterns of roles and rules, and sustained by a rationalising ideology” (S. Rose, 2000, p. 409). The capitalism of Western societies is one such, highly rationalised, system that has provided some groups

with considerable power to compel the behaviour of individuals and organisations and control the distribution of resources (Ashton et al., 2005).

However, many believe that the structure of capitalist societies goes largely unexamined; as does the crucial role it plays in people's experiences of health and illness (Harter et al., 2006; Jermier, 1998; Oliver, 1999; U'Ren, 1997). They have observed that capitalism is a pervasive system (Foucault, 1980; Gramsci, 1971; Mumby, 1988, 1997) that has justified inequities in access to healthcare (Albrecht, 1992; Garfield, 1994; Hollingshead & Redlich, 1958) and contributed to significant disparities in health outcomes (Jermier, 1998; Oliver, 1998, 1999; U'Ren, 1997). A plethora of scholarly evidence, over many decades, has demonstrated that those in lower economic classes have been more likely to receive treatments grounded in administrative logic (Foucault, 1986), such as increased hospitalisation with greater rates of prescribed and tranquillising medications, and have had significantly less access to other, more genuinely therapeutic, responses such as talking-based or relational therapies, respite and retreat care, private psychiatrists, psychotherapists and psychologists (Abas et al., 2003; Duncan et al., 2004; Oliver, 1998, 1999; Mosher, 1999). This has meant that the quality of healthcare, like other goods and services, is distributed unevenly in a capitalist society and is dependent upon the ability to pay (U'Ren, 1997).

The capitalist "value" of health has inevitably been tied to the rationale of economic enterprise and people's capacity, or incapacity to work., This has led to perceptions of illness as being socially unacceptable or personally irresponsible (M. Brunton, 2000; Harter et al., 2006; Pierret, 1993; Zoller, 2003). The medicalisation of madness and segregation of the mad, therefore, was as much for the economic good health of society as it was for the individual (N. Rose, 1996, 1998; Jermier, 1998). Separating the able bodied from the *dis*-abled, by placing people in institutions, resulted in a non-*productive* group of people who were unable to participate in capitalism, as producers, products or even *consumers* in a competitive market (Scull, 1979).

The subsequent monopoly and control over psychiatric services has, in turn, provided powerful disincentives for the mental health “market” to re-organise itself (Jermier, 1998; Moncrieff, 2007; Oliver, 1999; U’Ren, 1997; Whitaker, 2004). Similarly, tensions in ideological concerns between notions of *providing services* and *producing goods* (Ashton, 1999; Oliver, 1999; Reay & Hinings, 2005) have prompted commentators to maintain that the modern health professions are “not simply the dominant or most important providers of a particular service; instead they effectively monopolise a service market” (Samson, 1995, p. 129).

However, there have been some serious repercussions of a market approach to healthcare. Importantly, it has reinforced the ethos of evidence-based practice, whereby funders of health care have prioritised administrative and fiscal efficiencies, rather than clinical effectiveness, in treatment decisions (Ashton, 1999; Duncan et al., 2004; Hubble et al., 1999; N. Rose, 1996; Sawyer, 2005). This has also been indicative of the rise of managerialism in health and mental health services including the community NGOs (Hwang & Powell, 2009; Zoller, 2003).

Managerialism and consumerism

Initially, the professionalisation of organised medicine, including psychiatry, enabled it to resist the encroachment of corporate managerialism in healthcare. As discussed in the Background chapter, the medical professions enjoyed almost autonomous control over the conditions and conduct of their work. Specifically, they were not required to engage with considerations of cost efficiencies and market share (O’Reilly & Reed, 2011; Reay & Hinings, 2005; Scott, 2008; Scott, Ruef, Mendel, & Caronna, 2000; U’Ren, 1997).

Notwithstanding, and despite tensions between professional interests and managerial values and priorities, scholars generally agree that corporate managerialism has now become thoroughly naturalised and institutionalised in Western healthcare systems (Fougere, 2001; Hwang & Powell, 2009; Reay & Hinings, 2005; Zoller, 2003). Discourses more appropriate to a business, such as

efficient management practices, fiscal responsibility for the public purse and providing *value-for-money* have systematically replaced traditional health concepts of care, cooperation and trust (Ashton et al., 2005; Boston et al., 1999; Fougere, 2001; Knights & Morgan, 1991). Similarly, managerial indicators of success and service outcomes have been routinely reduced to the achievement of instrumental goals such as service access, exit and bed occupancy (Hwang & Powell, 2009; Harrison, 2010).

Managerial perspectives in healthcare, sustained by the same functional rationality underpinning both medical and business practice, have emphasised a quest to maximise gains in fiscal efficiencies and service outputs, and minimise costs and concessions to other stakeholders (Alvesson & Deetz, 2000; Hwang & Powell, 2009; Mumby, 1998). This has further advanced the commodification of health and reinforced hierarchical patterns of roles, relationships and regulatory practices in the organising of healthcare (Fakhoury & Priebe, 2007; S. Rose, 2000; Scott et al., 2000; Sillence, 2001). As a consequence, organisational practices of review and evaluation have been reduced to a mere concern with organisational effectiveness and productivity (Stohl & Cheney, 2001) rather than critical examinations of issues of social justice, equity and change (McCashen, 2005; Ochaka, Nelson, & Lord, 1999; Sullivan, 1994; Warriner, 2001).

In many Western health systems, including Aotearoa\New Zealand, the introduction of capitalist imperatives of fiscal retrenchment, alongside a managerialist discourse, were presented as increases in consumer *choice* and consumer *satisfaction* (Reay & Hinings, 2005). In mental healthcare, policies, including recovery, implied that consumers of all kinds would be better informed about their healthcare, have higher expectations of service outcomes and, therefore, be enabled to have greater control in shaping services (W. Brunton, 2004; *Central Potential*, 2008; Davis & Ashton, 2001; O'Hagan, 1999). The Health and Disability Commissioner Act 1994 and the Code of Consumers' Rights (Health & Disability Commission, 1996), for example, formally endorsed the rights of mental health consumers to some of the dignity, informed consent and rights of review that the rest of society enjoyed (Cresswell, 2009; Everett, 1994).

But these shifts in the discourse exemplified tensions between notions of consumers as people with apparent power to determine the ways their health needs were met, and the notion of health and healthcare as marketable commodities, concerned with money and even profit (Davis & Ashton, 2001; Fougere, 2001; Tilly, 1996). In reality, there was no significant change in the distribution of power or mobilisation of resources in mental health organisations (Ashton et al., 2005; Harrison, 2010; Labonte, 1996; Reay & Hinings, 2005). In fact, several commentators claimed that market-driven mental health reforms converted the notion of community care into a cruel euphemism for community neglect (W. Brunton, 2004; Durie, 1994; Joseph & Kearns, 1999; Mason, 1996; Mental Health Foundation, 1987).

Managerialism and consumerism, as discussed in the Background chapter, contributed significantly to the commodification of health and healthcare (Reay & Hinings, 2005), and conferred power and advantage to some groups while disempowering others. Specifically, structural and conceptual hierarchies within Western health systems naturalised the domination of professional identities and disguised the effects on those made vulnerable by the inequities of the capitalist state (Albrecht, 1992; Hwang & Powell, 2009; Knights & Morgan, 1991; O'Reilly & Reed, 2011; N. Rose, 1998; Samson, 1995; Scott, 2008; Turner, 1995). Internal frictions notwithstanding, alliances between socially powerful professionals have made it more difficult to introduce other perspectives, or make systemic change.

Professionalism and power

Professional status is inseparable from public perceptions of social legitimacy and credibility (Mumby, 1988; Hwang & Powell, 2009; O'Reilly & Reed, 2011; Scott, 2008). Rob Warriner (2010) has described the relationships among biomedical professionals and society as follows:

For a long time, there has existed an unspoken covenant between medicine, community and the State. The State supported the right to medical care, medicine delivered

treatments to professionally agreed standards, and both gained the respect of an approving community, which [in completing the loop] secured the political and social legitimacy of health. The success of this arrangement was underpinned by unquestioned trust in the integrity of the medical professions (p. 76).

Professional credentials are achieved only after years of specialised training (Hwang & Powell, 2009; Samson, 1995; Turner, 1995) and unsurprisingly, those so accredited have sought to preserve their higher social status by defining and controlling access to specialist knowledge and expertise (Cheney & Ashcraft, 2007; Foucault, 1963, 1973). In turn, the socially rationalised perception of the need for technical and specialist expertise has underscored the belief in professional power, and led inevitably to professionally controlled systems of health and welfare services (Hwang & Powell, 2009; O'Reilly & Reed, 2011; Scott et al., 2008; Turner, 1995).

Constructions of professionalism, embedded in the ideological bases of biomedicine and managerialism, have created an almost impenetrable alliance in the organisation of healthcare (Alvesson & Deetz, 2000; Hwang & Powell, 2002; Scott et al., 2000). Increasingly, professional and managerialist interests, through their greater ability to influence strategy and policy, have reproduced and legitimated their preferred models of service design and practice, including the community sector (Ashton et al., 2005; Davis & Ashton, 2001; Frumkin & Andre-Clark, 2001; Harrison, 2010; O'Hagan, 2009c; Reay & Hinings, 2005).

Western health systems have, traditionally, been based on patriarchal relationships between an authoritative, but benign, expert and a willing, compliant and *inexpert* "patient" (Alderson, 1998; Reay & Hinings, 2005; Waitzkin, 1991). However, critical scholars have argued that "medical dominance is not a trans-historical and invariant property of the medical profession" (Samson, 1995, p. 55), but an expression of situated social, political and cultural arrangements that have conferred authority, privilege and power (Ashcraft & Pacanowsky, 1996; Ashcraft & Mumby, 2004; Turner, 1995).

Equally, these scholars have disparaged functionalist assumptions that doctors and patients are equally subject in the same social system (Oliver, 1998; Parsons, 1975), claiming that such perspectives have ignored the power relationships inherent in such social orders (Foucault, 1963, 1980; Jermier, 1998). Stephen Rose (2000), for example, has described the professionalised system for the diagnosis and treatment of psychological distress as “a form of ownership of the power to define the reality of the other, to control and contain the other’s meaning by interpretation of their experience” (p. 404). The privileged position of this “expertise” has significant implications; not least of which is that consumers are offered, and receive, only the treatments and professional responses in which the practitioner is “expert” (Duncan et al., 2004; Hubble et al., 1999; S. Rose, 2000; S. Rose & Black, 1985).

Foucault and others have been critical of the ways that the normalisation of biomedicine, as well as alliances among professional groups, has determined the ways in which deviance has been constructed, classified and regulated (Cheney & Ashcraft, 2007; Conrad & Schneider, 1990; Fee, 1999; Foucault, 1963, 1973, 1980; N. Rose, 1998; Scull, 1977; Turner, 1995). Similarly, functionalist valorisation of conformity and compliance has driven professional efforts to concentrate on either *reforming* deviancy or excluding it from society (Foucault, 1973; Frances, 2013; Habermas, 1987; Oliver, 1999; N. Rose, 1998; Scull, 1977).

Social norms, social policy and constructions of deviance

Every society produces its own truths and these become the “common sense” of the social imagination and are embedded in its social institutions. The normalising and regulatory consequences of these social processes underpin organisational communication, organisational forms and organisational practices (Alvesson et al., 2008). In Western societies, for example, the perceived superiority of scientific methods has led to bio-psychiatry becoming socially normative and legitimated (Bracken & Thomas, 1999; Dutta & Zoller, 2008; Foucault, 1963, 1973; Pilgrim & Rogers, 1999; Samson, 1995; Turner, 1995). However social constructions of normality have simultaneously constructed discourses of deviance, and this has been problematic for people who have

experiences of serious psychological distress because psychological *norms* and psychosocial *deviations* are culturally situated, and not measurable by objective, scientific indicators (Bracken & Thomas, 1999; Kutchins & Kirk, 1997; Oliver, 1998; John Read, 2004; Sayce, 2000; Szasz, 1974).

Instead of perceiving “deviants” as a minority of outsiders, and doctors as universally principled and benign, critical scholars have sought to demonstrate that people, characterised only by their dissimilarity from social norms, have been constructed as inadequate or disabled (Coleman, 1999; Oliver, 1996; Pearson, 2000; Sayce, 2000). In addition, societies have tended to respond to madness very differently from other “normal”, but overwhelming, experiences such as grief, war, natural disaster and other forms of trauma (MHAC, 2008). Instead, discourses of deviance have led to marginalisation and powerlessness for groups whose behaviour has caused social indignation merely because it is fundamentally non-conformist (N. Rose, 1998; Scheff, 1974).

Notions of *normal* and the theory (Wolfensberger 1980, 1983), ideology (Dalley, 1988) and practice of *normalisation* have been strongly contested (Canguilhem et al., 1989; Oliver, 1998, 1999). However, Western health and disability systems have tended to accept, uncritically, the valorisation of the normalisation principle (H. Brown & Smith, 1992; Dalley, 1992; Oliver, 1998, 1999; Wolfensberger, 1980, 1983).

Normalisation, as a principle of medical practice, has relied on professional judgements of an individual’s behaviour, their “functional” independence (Waghorn, Chant, & King, 2007; Ware et al., 2007) and their capacity to conform (Bracken & Thomas, 2001; Dellar, Lesley, Watson, & Curtis, 2000; Foucault, 1973; Grob, 1995; Warner, 2004). These professional constructions of *normality* have generally overlooked “the extent to which people are able to exercise their rights and participate, by choice, in the ordinary activities of citizens” (Mental Health Commission, 2009, p. 1).

Michael Oliver (1998, 1999), an outspoken critic of normalisation theory and practice, has advocated for acceptance of the “different”, or “deviant” participating in their communities. He, and others, have contended that the

normalisation discourse has pressured marginalised groups to be submissive, uncomplaining, compliant and dependent in order to conform to notions of appropriate behaviour (Carling & Allott, 1999; Dalley, 1992; Oliver, 1996; Sayce, 2000, 2001; Spandler, 2007). They have argued further, that conforming to others' expectations of behaviour does not lead to transformation of the circumstances of people's lives, which continued to be economically and socially deprived (Deegan, 1996; Oliver, 1998, 1999; Sayce, 2000, 2001; Spandler, 2007).

These circumstances have been exacerbated, rather than relieved, by a persistent and explicit tension between a social imperative to defend the wider interests of the *normal* community and the less compelling mandate to safeguard the rights of citizenship for those on the margins of society (Carling, 1995; Chamberlin, 1998; Lord & Dufort, 1998; Rappaport, 1987). Thus, there have been significant tensions within communities, resulting in social backlash, stigma and discrimination, poverty and homelessness (Anspach, 1979; Schneider, 2010; Mental Health Commission, 1998; Vaughan & Hansen, 2004).

People diagnosed with mental illness have typically experienced a quality of life inferior to the rest of the population (Leibrich, 1998; Mental Health Commission, 1998; Sayce, 2001; Spandler, 2007). Critics have argued that the secondary impacts of mental disorder, i.e. social inequity and social exclusion, have restricted people's lives much more than the symptoms of so-called illness (Sayce, 2000, 2001; Spandler, 2007; Sullivan, 1992; Ware et al., 2008). These circumstances have not only led to individual alienation, low social status, despair and hostility, but have excluded people from the social participation that is central to recovery discourses (Banks et al., 2004; Sullivan, 1992; Ware et al., 2008; Warriner, 2001, 2010).

The belief that madness is an entirely negative and valueless experience has also justified the coercion of people into environments and treatments they have not wanted (Barker, 2003, 2011; O'Brien & Golding, 2003; Pescosolido et al., 1999; Jacob Read, 2003a). In fact, diagnostic labels themselves have proved to be stigmatising within both hospitals and general society (Carson, 1997; Kamens, 2011; Pilgrim, 2007; Saleeby, 2001). David Pilgrim and Anne Rogers

(1999) have described the phenomenon of diagnosis as a “degradation ritual” (p. 113) that relentlessly strips away a person’s identity and sense of self. Others have argued the pathologising of human experience has reinforced social stereotypes and encouraged depersonalisation (Anspach, 1979; Canguilhem et al., 1989; Pilgrim & Rogers, 2005c; Schneider & Remillard, 2013). Aotearoa\New Zealand psychologist John Read (2005) has further contended that the promotion of “mental illness as an illness like any other” (p. 596) in destigmatisation campaigns has generated fear and prejudice through “destructive pessimism” about a person’s chances of recovery (Chalmers, 2001; Moncrieff, 2008; John Read et al., 2005; Vaughan & Hansen, 2004).

Studies show clearly that social assumptions, expectations and beliefs about groups of people determine what others see in their behaviour (Luske, 1990; van Hoof, van Weeghel, & Kroon, 2000; Vaughan & Hansen, 2004; Ward, 2009). Therefore, stigmatised identities have frequently become self-fulfilling prophecies, and people, with experiences of psychological distress, come to believe that they are chronically disabled and valueless (Ackroyd & Wyllie, 2002; Anspach, 1979; Oliver, 1998; Scheff, 1974; Schneider, 2010; Schneider & Remillard, 2013).

Critical scholars make an important distinction between discourses of social exclusion and social inclusion; although these are frequently used as unproblematic opposites by the lay public (Morgan, Burns, Fitzpatrick, Pinfold, & Priebe., 2007; Oliver, 1998; Perkins & Repper, 2013; Spandler, 2007). The concept of social exclusion has been a key discursive feature of social models of disability and mental health (Harter et al., 2006; Morgan et al., 2007; Powell, 2011; Repper & Perkins, 2003; Ware et al., 2007). These models emphasise the disabling nature of societal and environmental structures and systems, beyond individual problems, that form barriers to people’s full participation in community life (Oliver, 1996, 1998; Sayce, 2000, 2001; Spandler, 2007; Warriner, 2001). It also refers to the institutionalised discrimination experienced by people with diagnoses of mental illness when attempting to participate in education,

employment and other aspects of civil society (Lapsley & Yee, 2004; Perkins & Repper, 2013; Sayce, 2000, 2001; Spandler, 2007; Ward, 2009).

In contrast, several scholars note a subtle shift to a discourse of social *inclusion* that has threatened to obscure, rather than remove, the social structures that have generated and sustained exclusion (Harter et al., 2006; Morgan et al., 2007; Sayce, 2001; Spandler, 2007; Ward, 2009). Ideas of social inclusion, alongside notions of normalisation, have emphasised the need for individuals to “fit in”, rather than pressuring communities to become more accepting of difference. The inclusion discourses have implied that social and political change is the gift of the powerful to be bestowed on the powerless. Presumptions of a desire to be “included” have “become important ways of ensuring that the marginalised and excluded feel they have a stake in the modern social order” (Spandler, 2007, p. 10) and are, therefore, invested in their own compliance and conformity (Sayce, 2001;).

Critics have also challenged assumptions that the efforts of exclusionary agents, (e.g. communities, institutions and markets), to *include* vulnerable groups, are self-evidently benign rather than systematic and coercive (Mancini et al., 2005; Oliver, 1999; Spandler, 2007; Ward, 2009). As Heather Zoller (2005, 2012) has noted, there are few examples where privileged and powerful social groups have willingly given up power to others. Instead, these scholars have claimed, proponents have used the language of *inclusion* to confer limited equality on marginalised groups once they have achieved an “acceptable” degree of insight and behaviour; but have not challenged the legitimacy of the status quo (Dalley, 1992). Therefore, as Rob Warriner (2010) has commented: “Social inclusion and integration have become common mantras of service development, [yet] *exclusion* and *un-integration* remain the common experience for people using mental health services” (p. 74).

Organisational and national discourses, policies and strategies of *inclusion* have also perpetuated a focus on individual efforts, rather than environmental constraints that pervade the settings in which vulnerable people live and act (Deegan, 1996; Mental Health Commission, 2011; Ministry of Health, 2006,

2012b; Spandler, 2007; Warriner, 2010). In the mental health sector, these discourses have tended to dilute important concepts. For example, an empowering notion such as *self-determination* has been limited to *consumer choice*; service user *leadership* reduced to service user *involvement*, and human rights, personal power and *organisational* responsibilities diminished by an emphasis on *self-responsibility* and independence (Kendrick, 1997; O'Hagan, 2009c; Spandler, 2007; Warriner, 2009, 2010). These policy directions have occurred despite research showing that people, groups and communities are less vulnerable to illness and distress when they have personal power over their life circumstances. (Daniels, Kennedy, & Kawachi, 1999; Zoller, 2011).

Despite appearances of political and ideological change, social policy and social reform seldom alters the dynamics of power or challenges the legitimacy of knowledge constituting interests (Ashton et al., 2005; A. Brown, 2004; Mumby, 1988, 2008; Prichard, 2009; N. Rose et al., 2006). Typically, social policy has preserved inequitable arrangements and materialised these in institutionalised practices that have prioritised individual responsibilities for well-being rather than systemic analysis and change (Kendrick, 1997, 2012; Oliver, 1999; O'Reilly & Reed, 2011; Pilgrim, 2005; Warriner, 2010). Publicly funded organisations, such as mental health services, are peculiarly vulnerable to the, frequently tacit, ideological shifts and normative fluctuations that influence national policy (W. Brunton, 2005; Davis & Ashton, 2001; Fougere, 2001).

Rob Warriner (2010), among others, has noted, that when alternative discourses such as recovery have emerged to challenge mental health policy, powerful interests have routinely outflanked other perspectives with the rhetoric of traditional discourses and traditional disciplines, and ensured there is little substantial change (Ashton et al., 2005; A. Brown, 2004; Oliver, 1999; N. Rose, 1998; S. Rose, 2000). The situation has been further exacerbated by the mass-mediated promotion of scientific research in mental health (Cutcliffe & Hannigan, 2001; Gerbner, 1980; Kline, 2006; Nairn et al., 2011; Philo, 1996; Seale, 2004). Therefore, despite apparent discursive shifts (O'Hagan, 2004, 2009a; Venuti, 1992), the experience of many stakeholders in mental health

services has been very much “business as usual” (Ashton et al., 2005; Barber, 2005; Barker, 2003; Pearson, 2004; Warriner, 2010) .

Similarly, individualised constructions of health and illness have effectively deflected public and political attention away from systemic problems, social conditions, and the environment. Individualism in Western contexts has made health a purely personal responsibility; thus emphasising self-change at the expense of social change. In the section that follows, I elaborate on the implications of individualism on maintaining inequitable social systems and the marginalisation of vulnerable populations (Broadfoot & Munshi, 2007a).

The effects of individualism in healthcare

The naturalisation of an individualist perspective has been an indispensable characteristic of capitalist logic, epitomised under neoliberalism and a largely Western managerialist approach to organising (Dutta, 2015; Hwang & Powell, 2009; Jermier, 1998; Oliver, 1999; O’Reilly & Reed, 2011). This has led many neo-liberal scholars to disregard social, moral and ethical challenges that might impede the generation of wealth (Ashton, 2005; Boston et al., 1999; Frumkin & Andre-Clark, 2000; Mumby, 1988; U’Ren, 1997). In other words, social analyses that address complex and interactive socio-political factors, including discrimination based on social categories such as gender, race and disability, have been relegated to the background (Ashcraft & Pacanowsky, 1996; Oliver, 1998, 1999; Trethewey, 1997; Warner, 2004).

Unfortunately, ideological valorisation of individual effort and the “entrepreneurial endeavour” (M. Brunton, 2000; Gill, 2011) has led to individual lifestyle theories which have shifted responsibility for the health of both the “self” and society on to individuals, making success a function of individual effort and hence “failure” a personal responsibility. This has encouraged the development of the “individual defect” paradigm in health and mental health discourses that have continued to attribute problems to individual failure, defects and poor choice-making (Dutta & Zoller, 2008; S. Rose, 2000; Zoller, 2003, 2011) at the expense of addressing important social, political and

contextual factors (McCashen, 2005; Mental Health Commission, 2007b; John Read et al., 2004; S. Rose, 2000; Rappaport, 1995). This has meant that personal life circumstances, including trauma, have not typically been addressed in any psychological, political or pragmatic sense (Jureidini, 2012; Oliver, 1999; S. Rose, 2000; U'Ren, 1997).

Scholars have also argued that psychiatry has absorbed the modern obsession with life as an “enterprise of oneself” and, in isolating the individual, has left genuine social problems and conflicts untouched (Anthony, 1993). Although cultural, economic and socially systemic issues may be considered stressors, it is only *individual* emotional and psychological symptoms that have been considered of medical significance (U'Ren, 1997). Thus, the “self” has become a personal project to be continually and actively assessed, managed, worked and improved upon (Alvesson & Willmott, 2002; Bracken & Thomas, 2010; Lupton, 1995; Petersen, 1996, 1997; N. Rose, 1990, 1998)

The communication of self-responsibility for good health starts early in Western societies (M. Brunton, 2000; Zoller, 2003) and normalised accounts have generally ignored factors outside an individual’s control (M. Brunton, 2000; Durie, 1999, 2001; Labonte, 1997; Pierret, 1993; Pulotu-Endemann, 2001). This has further reinforced and justified the social production of “mediated and interpersonal prevention messages aimed at self-discipline” (Zoller, 2010, p. 484) as if these were independent from the social, political, and structural contexts that constrain or enable good health decisions (M. Brunton, 2000; N. Rose, 1990; Zoller, 2010). Peter Miller and Nikolas Rose (1988) have further argued that it is the intent of governments to secure socio-political objectives by regulating the lives of individuals and populations. This has not only made the conduct of personal life crucial to the exercise of political and managerial power, but has also constructed the vocabularies of “social well-being” and the “public good” to rationalise political strategies such as the persistent quest for profit and gain. This governmentality has also encouraged the assumption of managerial authority over the workplace and organisational lives of individuals (Miller & N. Rose, 1988; Miller & O’Leary, 1987; Zoller, 2003).

In addition, the importance of paid work, or “gainful” employment, and the capacity to consume goods and services have underpinned measures of social well-being and “the means through which good character is expressed and success achieved” (U’Ren, 1997, p. 3). For users of mental health services, unable to find or maintain work, this has further discriminated against them and worked against alternative understandings of well-being (Chamberlin, 1998; Leibrich, 1998; Yee & Lapsley, 2004). Stephen Rose (1988), among others, has highlighted how harsh social circumstances have been dismissed as individual or cultural deficits, and minimised social inequities and discounted the need for social change (Prichard, 2009; S. Rose, 2000; Schneider, 2010).

Critical scholars have contended that fragmenting communities into collections of individuals acts in favour of privileged discourses by discouraging collective action (Flanagin, Stohl, & Bimber, 2006; Lerner & Craig, 2005; S. Rose, 1972; Zoller, 2005, 2011). Similarly, in the field of health communication, scholars have advocated health promotion models, including many indigenous models, which incorporate a range of important social and environmental factors, identified as prerequisites for mental health and well-being (Carling & Allot, 1999; Mental Health Commission, 1998; Sayce, 2000; World Health Organisation, 2005). These models recognise that individual well-being is inseparable from the contexts of people’s families, communities, cultures and the socio-political circumstances that affect them (Durie, 1994, 1998, 2001; Labonte, 1997; Ministry of Health, 2001b; World Health Organisation, 2005; Zoller, 2011). Similarly, recovery and other social models of well-being have emphasised the *personal*, rather than constructing the *individual*. William Anthony (1993), for example has described recovery as a “deeply personal mission of living” and developing new meaning and purpose in life after growing “beyond the catastrophic effects of mental illness” (p. 15).

Ironically, while socio-political influences have located “problems” within individuals, the “solutions” have remained within the purview of specialist expertise and the intellectual technologies of social order (Foucault, 1980; Lupton, 1994; Miller & N. Rose, 1990). Therefore, although treatment responses

are based on professional expertise, a “failure to respond” to treatment is still considered evidence of an individual’s intransigence rather than a flawed practice model (Duncan et al., 2004; Hubble et al., 1999; S. Rose, 2000; Zoller, 2011). This has led to mental health service users being further stigmatised by being labelled “unmotivated”, “treatment resistant” or “non-compliant”. Such arbitrary judgements have not been accompanied by corresponding expectations for practitioners to be critically self-reflective, or accountable, outside their professional responsibility.

In addition, while health *issues* may be treated as individual, there has been little legitimate space for individual participation in *healthcare* (Clark & Krupa, 2002; Fitzsimons & Fuller, 2002; Lord et al., 2004; O’Hagan, 2009c; Rappaport, 2002; Waitzkin, 1991). Most scholars agree that personal agency and empowerment are critical to managing health and well-being, and have disputed the equivalence of personal agency and individualism (Carey, 2005; Perkins, 1999; Jacob Read, 2003a; S. Rose, 2000; Zoller, 2011). Nevertheless, this boundary remains conveniently blurred in managerial and biomedical perspectives that have institutionalised individualist approaches and worked against collective social action and community responsibility for care of the vulnerable (Anspach, 1979; Dalley, 1988; Lerner & Craig, 2005; Zoller, 2005).

In the next section, I investigate the organisation of mental health care through the lens of the third problematic described by Mumby and Stohl (1996, 2007). In particular, I examine the effects of organisational configurations on the introduction of alternative models and practice such as recovery. I also examine the identity, role and niche the community NGOs have inhabited within mental health systems, as well as the opportunities for organisational transformation in the face of powerful institutions. These discussions frame the literary background to my second research question, which seeks to answer how institutional dynamics are constructing, constraining or contradicting organisational practices in terms of becoming recovery-oriented.

The problematic of organising of mental health care

In the previous chapter, I outlined the organisational arrangements of the Aotearoa\New Zealand mental health system within its social-political context. It was apparent from that discussion that cultural and political constructions of madness, as well as the shifts and vicissitudes in social discourses over time, have inevitably affected the establishment, structure and configuration of the mental health sector (W. Brunton, 2001, 2004; Foucault, 1973a, 1973b; Samson, 1995; Turner, 1995). How values and practices are constructed and preserved through organisational talk, and the organisational arrangements that enable or constrain action (Cheney, 1999), have serious implications for organising the mental health sector as recovery-oriented in Aotearoa\New Zealand.

Barbour and Lammers (2007) have described how “enduring beliefs and practices both transcend and shape particular organisations and organising” (p. 201). In other words, how discourses of mental health, which are naturalised in everyday conversation, social policy and organisational communication practices, influence the organisational arrangements and management of mental health resources (Zoller, 2011). These issues are particularly significant for less powerful organisations, such as community NGOs, when considering their ability to preserve the integrity of their founding ideals and manage the inevitable fluctuations in both the internal and external environments, while simultaneously engaging responsively with the larger community (Cheney, 1999, 2002).

These circumstances have led several commentators to question whether apparent shifts in the organising of mental health care, specifically to a recovery orientation and the move to community care, have been accompanied by substantive changes in the distribution of power and the re-mobilisation of resources (Ashton et al., 2005; Clark & Krupa, 2002; S. Rose & Black, 1985; Townsend, 1998). Therefore, I examine literature, through the critical lens of the problematic of organising (Mumby & Stohl, 1996, 2007), that addresses the ways in which mental health services have generated, managed, or resisted

inequalities in mental healthcare, and specifically community NGOs (Zoller & Harter, 2010).

Community and non-government organisations

Organisational scholars have agreed that NGOs have become increasingly visible and active in various sectors of social life and have their own character, outside the environment of competitive, commercial organisations. Yet they have not been adequately represented or explored in the field of organisational communication (Ganesh, 2005; Lewis, 2005; Harrison 2010; O'Brien et al., 2009). Several scholars have argued that not only has the “third” sector been under-represented in critical organisational studies (Ganesh, 2003), but that ordinary organisational members and workers have typically been outside the academic gaze (Ackroyd & Thompson, 1999; Broadfoot & Munshi, 2007a; Mumby, 2005).

As previously discussed, the community based NGOs in Aotearoa\New Zealand emerged from a long history of politically determined, and publicly funded, approaches to the care and treatment of the “mentally ill” (W. Brunton, 2005; Health and Disability Commission Working Group, 2010; O'Brien et al., 2009; Tennant et al., 2008). Therefore, they have been vulnerable to fluctuations in societal and political norms and subordinate in their organisational relationships with clinical services (Harrison, 2010; Warriner, 2001).

Politicisation and conflict: The non-government organisation sector in Aotearoa\New Zealand

As was evident in Chapter 2, the reorganisation of the health sector in 2000 was intended to increase community involvement in health planning and address the inequities in access to healthcare (Ashton, 1999; Ashton et al., 2005; Fougere, 2001; *Platform Trust*, 2008). However, very few rigorous studies have been undertaken to determine the merit or otherwise of these arrangements (Boston, 1996). In addition, the mechanistic and individualist approach of Western healthcare systems has been particularly amenable to largely bureaucratic forms of organising such as the functional hierarchies of the DHBs in

Aotearoa\New Zealand (Deetz, 1992a, 1992b; McPhee, 1985; Mumby, 1988; Perrow, 1986). These arrangements have exemplified the concerns of critical scholars that theoretical preoccupations with the stories and perspectives of the powerful in organisations has afforded some groups greater opportunities to represent themselves and institutionalise their preferred organisational practices (Ackroyd & Thompson, 1999; Cheney & Cloud, 2006; Deetz, 1992; Harter et al., 2010; Holmer-Nadesan, 1996; Trethewey, 1997).

Studies of “community care” and social interventions provided by non-government mental health services have been rare throughout 20th century (Moncrieff & Crawford, 2001). In addition, as Angela Trethewey (1997) has maintained, organisational communication and management scholars have, historically, privileged the rational, public and goal-directed nature of organisations, and this has resulted in a marginalisation of organisations concerned with “women’s work” (Cheney & Ashcraft, 2007; Holmer-Nadesan, 1996; Trethewey, 1997). This systemic devaluation of human service organisations, coupled with low legitimacy and chronic underfunding, has also further marginalised the poor, the displaced and those diagnosed with mental illness (Oliver, 1996; Sayce, 2000, 2001; Spandler, 2007).

Global changes to systems of healthcare, such as the widespread valorisation of information communication technologies, and the effects of market economics have also had consequences for the economic survival, credibility and social legitimacy of the community sector (Fougere, 2001; Ganesh, 2003, 2005; Harrison, 2010; Lewis, 2005; *Platform Trust*, 2006; Sanders, O’Brien, Tennant, Sokolowski, & Salamon, 2008; Zorn et al., 2011). In addition, other sector groups frame the work that NGOs do, and the issues they are trying to address, very differently (Ganesh, 2005; Holmer-Nadesan, 1996; Trethewey, 1997).

This has created pressure on the community organisations to frame their organisational discourses, practices and issues as “fiscal efficiency”, “risk management” or technological deficits (Beck, 1992; O’Brien et al., 2009; N. Rose, 1998; Sawyer, 2005; Zorn et al., 2011), rather than social inequity and systemic

exclusion in order to preserve organisational credibility (A. Brown, 2004; Czarniawska-Joerges & Joerges, 1988; Prichard, 2009). It has also meant that organisational energy and attention has had to prioritise technological solutions to issues, contract driven practices and administration (Davis & Ashton, 2001; Ganesh, 2003; Ganesh & Barber, 2009; Harrison, 2010; O'Brien et al., 2009; Zorn et al., 2011).

The nature of service outcomes and measures of effectiveness has been of particular concern for the community NGOs, and are typically accountable to multiple stakeholders and vulnerable to environmental pressures (Ganesh, 2005; Harrison, 2010; Zorn, 2011). The importance of remaining accountable to their mission statements, constitutional values and service users has frequently been in opposition to financial and contracting accountabilities (Cheney, 1999, 2002; Fougere, 2001; Frumkin & Andre-Clark, 2000; Ganesh, 2003; Zorn, 2011). This, in turn, has created issues of organisational survival that have led to some organisations becoming “more concerned with justifying [their] own existence than in serving the public good” (Ganesh, 2003, p. 568). Contracting and funding arrangements have also restricted organisational responsiveness and innovation (Frumkin & Galaskiewicz, 2004).

Stephen Rose (2000), in his observations of the implementation of the empowerment agenda in a community action programme concluded that mental health services remained a “provider-driven, delivery based universe” (p. 409). He argued that most organisations operated under the illusory assumption that whatever services were provided would automatically be beneficial to “clients”. He criticised the measurement of service *outputs* such as access and availability, when *outcomes*, indicative of the appropriateness or efficacy of a service in actually meeting people’s needs, were ignored. Rose concluded that, disappointingly, the higher the level of service agency involvement in a person’s life the more likely that an “individual defect explanatory paradigm would prevail” (p. 410) and that service delivery systems would be protected (Kendrick, 1997; S. Rose, 2000).

Similarly, the naturalised dynamics of socio-political power have not only determined how choices are made in social policy, but have also constructed notions of “worthiness” and “deservedness” (Schneider, 2010), and established the values link between the recipients of policy resources and the way these resources are provided (Davis & Ashton, 2001; Labonte, 1996; Leclercq-Vandelannoitte, 2011; Schneider & Ingram, 1993). In other social discourses, for example, the unemployed, the “mentally ill” and other “beneficiaries” have been positioned as less deserving than, say, the elderly (Powell, 2011; Repper & Perkins, 1995; S. Rose, 1972; Schneider, 2010; Stewart, 2007). Consequently, organisations associated with marginalised groups have also had their opportunities to influence social policy or control resources similarly reduced, leaving them more likely to be on the receiving end of disabling policies and disempowering administrative arrangements (Oliver, 1998; Powell, 2011; Stewart, 2007). This has, in turn, reduced organisational accountabilities to service users, and their expressed ideals of living good lives in the community of choice (MHAC, 2008; Mental Health Commission, 2011) in favour of more powerful interests and priorities (Ashton et al., 2005; Ganesh, 2005; Harrison, 2010; Joseph & Kearns, 1999; McKnight, 1983; Oliver, 1999; Powell, 2011).

While most social observers have assumed that the NGOs have provided community care, scholarly commentators have agreed that the ideas sustaining mental healthcare delivery have continued to be supported by pathology-based funding that has rationalised the dominance of clinical services (Bracken & Thomas, 2005, 2010; Pilgrim & Rogers, 1999; Powell, 2011; S. Rose, 2000). Although shifting mental health services to the “community” has, to some extent, challenged the dominance of biomedical psychiatry, no coherent, coordinated system of alternative ways of organising the sector has yet been established to replace it (Durie, 1994; Mason, 1996; Mental Health Commission, 1998; Warriner, 1999). Other socio-political issues, such as the ethics of doing something *to* people, or *for* people, “for their own good”, alongside the use of coercion, have also largely gone unexplored (Anthony, 2006; Chamberlin, 1998; Minkowitz, 2006; O’Brien & Golding, 2003; Pearson, 2002). All of which has

meant that, in their endeavours to *realise their best intentions* (Barber, 2005; Ganesh, 2007; Townsend, 1998) the community NGOs have needed to become politically active and astute (Gawith & Abrams, 2006; Harrison, 2010; O'Brien et al., 2009; Trethewey, 1997).

However, the NGO sector has typically struggled for voice in the medico-centric dominance of key national forums, and the reluctance of government to engage with the sector effectively (Gawith & Abrams, 2006; Joseph & Kearns, 1999; Ministry of Social Development, 2001). Therefore, representation of these organisations and their contribution as a source of innovative, cost-effective services has seriously diminished (Harrison, 2010; McMorland et al., 2008; O'Brien et al., 2009; Peters, 2010; van Hoof et al., 2000). This has meant that the community organisations have continued to struggle to establish themselves politically as legitimate and credible alternatives to clinical services (Curtis & Hodge, 1994; Joseph & Kearns, 1999; Grob, 1995; O'Brien et al., 2001; Ministry of Health, 2001a; Ministry of Social Development, 2001; van Hoof et al., 2000; Warriner, 1999, 2001).

Defining community care

Community service models emerged as the focus shifted to community locations and community ideals (Kukler et al., 1998; Roen, 1999;) and ostensibly moved the focus of mental health service provision away from institutional facilities and ideologies towards the ordinary world of social practice (Joseph & Kearns, 1999; Ministry of Health, 2001; Sanders et al., 2008; Warriner, 2001). Service user literature, and much mental health policy, has emphasised the transformative power of community as a prerequisite for successful, competent living. However, considerable ambiguity about the term *community care* has remained; as well as the goals of such a policy in mental health service provision (O'Hagan, 2009b; Pilgrim & Rogers 1999; Pinfold, 2000; Powell, 2011; Torrey & Wyzik, 2000; Van Hoof et al., 2000; Warren, 1995; Warriner, 2001; Yip, 2000). Kam-Shing Yip (2000) in his analysis of the evolution of community care in Britain and the USA has even referred to the third and current stage of community care as *re-institutionalisation*.

Critics have argued that, to be effective, mental health services need to support people to be not only *in* the community but *of* it. As Kennedy, Horner and Newton (1989) expressed it: “Social contacts are at the heart of community integration; without repeated social contacts an individual has little chance of gaining acceptance by members of a community” (p. 58). In other words, “whatever a person is doing now needs to be connected in some meaningful and motivating” (Warriner, 2001, p. 21) way with social practices that promote participation, contribution and the opportunity to make changes in their life and circumstances (Carling & Allot, 1999; Carling et al., 1999; Coleman, 1999; Lapsley, 2002; Sayce, 2000; Spandler, 2007).

The recovery vision for Aotearoa\New Zealand described a society where “people with mental illness have personal power, full participation in their communities and access to a fully developed range of recovery-oriented services” (Gawith & Abrams, 2006, p. 142). However, little research has been undertaken on the effectiveness of efforts to implement a recovery orientation into organisational practice (Anthony et al., 2003; Barber, 2005; Bonney & Stickley, 2008; Davidson et al., 2006).

The construction of recovery oriented organisations: Organisational transformation

Scholars and commentators have emphasised that a recovery orientation in services would require fundamental shifts in how psychiatric disorders are understood, and in the mission, design, and delivery of mental health organisations (Anthony, 1993; *Central Potential*, 2008; Goldsack et al., 2005; Jacobson & Curtis, 2000; Onken et al., 2000). Many have argued that key to a shift towards a recovery orientation would be the increased visibility of people with lived experience of serious psychological distress as collaborators and leaders in service design and delivery (*Central Potential*, 2008; Chamberlin, 1988, 2004; Goldsack et al., 2005; O’Hagan, 2009c; Pearson, 2000, 2004; Jacob Read, 2003a; Warriner, 2009).

How recovery is constructed and expressed in everyday organisational realities is the key that connects my research questions. Jan Wallcraft (2009) has recently commented that, by now, it should be “uncontroversial that recovery is possible and desirable, and should be the main purpose of mental health services”. However, she and others go on to caution that the reality of service delivery has continued to emphasise functional maintenance rather than recovery (O’Hagan, 2009; Turner-Crowson & Wallcraft, 2002; Wallcraft, 2009) and, in general, treatment responses have continued to demonstrate professional preferences rather than user choice (Duncan et al., 2004; Gawith & Abrams, 2006; Hubble et al., 1999; O’Hagan, 2009c; Warriner, 2009).

Recent literature identified common themes for recovery discourses; particularly the nature of what is helpful, or not, in mental health organisations (Bonney & Stickley, 2008; Mancini et al., 2005; O’Hagan et al., 2012; Onken et al., 2000; Turner-Crowson & Wallcraft, 2002). Bonney and Stickley (2008), for example, undertook a meta-analysis of all British literature related to recovery in mental health services over the 20th century. They compared all relevant texts produced by three distinct stakeholder groups: service users, health care providers and policy makers.

From their analysis, they determined six broad domains of recovery in service provision: (1) identity; (2) the service provision agenda; (3) the social domain; (4) power and control; (5) hope and optimism, and (6) risk and responsibility. However, stakeholders differed significantly in how they defined recovery and experienced these domains. In particular, there were major distinctions between constructions of a recovery orientation, as envisaged by service users, with those of more powerful stakeholders (Bonney & Stickley, 2008; Davidson et al., 2006; O’Hagan, 2009; Swarbrick, 2006; Wallcraft, 2009).

Nevertheless, some consensus about the characteristics of a recovery orientation in mental health services emerged, and provided an important counter to biomedical orthodoxy (Farkas, et al., 2005; Jacobson & Curtis, 2000; Lapsley, 2004; Onken et al., 2002; Salyers, Tsai, & Stultz, 2007). In New Zealand, these are documented in several texts authored by service users (Banks et al.,

2004; *Central Potential*, 2008; Leibrich, 1998, 2000; O'Hagan, 1999, 2001) and some in collaboration with others in the field (Gawith & Abrams, 2006; Goldsack et al., 2005; MHAC, 2008). All these texts describe a recovery-orientation in services that is characterised by a hopeful, optimistic and holistic approach to care and support. This construction prioritised the enhancement of personal and environmental well-being and encouraged the involvement of friends, families and natural supports in the community (Banks et al., 2004; *Central Potential*, 2008; Gawith & Abrams, 2006; Goldsack et al., 2005; Lapsley & Nikora, 2002; Lapsley, 2004). In addition, these authors promoted a range of flexible service models within robust community networks related to employment, housing, and social participation (Banks et al., 2004; Barber, 2005; *Central Potential*, 2008; Farkas et al., 2007; Lapsley & Nikora, 2002).

Service user authors, and their allies, emphasised recovery approaches that acknowledged the unique circumstances of each person rather than the *one size fits all* service response that has generated the most resistance and frustration (Barker & Buchanan-Barker, 2005; *Central Potential*, 2008; Coleman, 1999; Leibrich, 2000; O'Hagan, 1994). Proponents also anticipated that recovery oriented services would be delivered in a range of environments including ordinary community settings (MHAC, 2008; Warriner, 2001). They also insisted that a recovery-orientation requires multiple, navigable and negotiated pathways into services rather than compulsive, coercive and trauma based access that has remained the norm (Chamberlin, 1998; Goldsack et al., 2005; Minkowitz, 2006; O'Hagan, 1999; Onken et al., 2000; Pearson, 2000; Rogers, Pilgrim, & Lacey, 1993; Slade, 2009).

Commentators generally agreed that recovery requires a range of treatment responses. Pilgrim and Rogers (1999) have described a "broad and unresolved tension" (p. 121) between physical treatments such as medication and talking-based or conversational therapies. Others, too, have advocated for responses that encourage people to reframe their stories in more helpful ways and allow them to "get on with [their] lives" (*Central Potential*, 2008, p. 24). These tensions have persisted despite service users' unequivocal assertion that

social support, including peer support and counselling, are essential to recovery (*Central Potential*, 2008; Leibrich, 2000; Mosher & Vallone, 1995; O'Hagan, 1999; Pearson, 2004; Peters, 2009). Specifically, service users have called for a renewal of "the art and skill of providing attentive support to people in crisis" (*Central Potential*, 2008, p. 21) so that they may feel secure within accepting environments at times of extreme vulnerability.

In general, the existence of supportive relationships, meaningful activities and effective traditional and alternative treatments were identified as influential in facilitating recovery (Banks et al., 2004; *Central Potential*, 2008; MHAC, 2008; *among many others*). Commentators argued, therefore, that not only should mental health services be redesigned but professionals should be retrained to more effectively communicate hopefulness and support people's efforts to get on with life beyond illness (Banks et al., 2004; Beck, 1992; *Central Potential*, 2008; Goldsack et al., 2005; O'Hagan, 2001, 2004 Slade, 2009; Torrey & Wyzik, 2000).

Service users have claimed that their participation in service design, delivery and organisational transformation has been dependent on how removed they are from active care and treatment in clinical services (Read, S. Rose, 2000). Alongside a shift in professional responses, therefore, they have argued for the establishment of a range of peer support models to be available within services including crisis response (Gawith & Abrams, 2006; Goldsack et al., 2005; O'Hagan, 2009c; Mosher & Boyle, 2004; Peters, 2009; Repper & Carter, 2011).

In general, service user authors and others have actively rejected many of the defining features of most contemporary mental health services, and most have noted that current mental health service environments and common practices actually constrain recovery (Anthony, 1993; Mancini et al., 2005; Onken et al., 2000; Rapp, 1998; Turner-Crowson & Wallcraft, 2002). In addition, the contribution of the community sector to recovery and social well-being has largely been undervalued and its potential untapped (Harrison, 2010; Ministry of Social Development, 2001; Peters, 2010; Warriner, 2001, 2010). These

circumstances have maintained despite commentators clearly articulating the values and features of organisational discourses and practices that would support recovery (Turner-Crowson & Wallcraft, 2002).

The significance of values in organisational practices

Organisational values are embedded in all aspects of organisational communicative practices, systems and structures including recruitment, training, performance management and service delivery (Cheney, 1999, 2002; Frumkin & Andre-Clark, 2000; Stewart, 2007). The critical service outcomes and values of the community organisations, expressed in their mission and vision statements, have largely included enhancing peoples' capacity to live well in desirable environments and to support their transitions into ordinary life within a community; all of which are part of health and social policy (Ministry of Health, 2005; MHAC, 2008). In other words, they have intended to enact the values of a recovery orientation in their service delivery, as well as aspiring to a more enriched, humane and socially equitable society where larger social values are enacted and ideals made liveable (Ganesh, 2007; MHAC, 2008; Warriner, 2010).

However, the ways in which organisational values are expressed through mission statements and Trust Deeds, have frequently been in conflict with less explicit, underlying and extra-organisational expressions such as policy frames that have prioritised some goals and constrained others (Cheney, 2002; Ganesh, 2003, 2005; Frumkin & Andre-Clark, 2000; Zorn et al., 2011). These conflicts have also been evident in the relationships among the NGOs, the DHBs, and the Government (Harrison, 2010; *Platform Trust*, 2008).

The implementation of national and sector policy has generally determined the perspectives and interests that have privileged some values over others and some populations over others (Repper & Perkins, 1995; Schneider & Ingram, 1993; Stewart, 2007). A significant example has been the imposition of managerial paradigms and a market model on community organisations (Lammers et al., 2003; Lewis, 2005; *Platform Trust*, 2008; Stewart, 2007). The associated values of efficiency, competition and performance, have contrasted,

and often conflicted with, more traditional community paradigms, which have stressed cooperation and trust; as well as more contemporary social service values such as consumer rights, cultural appropriateness, and service responsiveness (*Central Potential*, 2008; Durie, 1985; O'Hagan, 1999; Schneider & Ingram 1993). These values conflicts have meant that community NGOs have struggled to establish a niche and identity, distinct from the more dominant clinical services, in order to become recovery-oriented (MHAC, 2008; Warriner, 2001).

Developing an identity and niche for the community non-government organisations

Researchers have described organisational identity in terms of both “continuity and essence” (Cheney et al., 2004, p. 109). While accepting this fluidity, organisational identity is typically anchored to how organisations make sense of themselves and how others perceive them; it involves what is core, distinctive, and enduring about an organisation’s character (Cheney & Christensen, 2001; Cheney et al., 2004; Czarniawska-Joerges, 1994; Dey & Teasdale, 2013). Therefore, identity not only expresses the preferred values of an organisation, but is also a determinant of how organisational members act, interpret, negotiate and construct their organisational reality and relationships with the external, social world (Weick, Sutcliffe, & Obstfeld, 2005).

Some commentators have noted that the emergence of a distinct identity, niche and unique subject position for the community NGOs has been made difficult because the development of the sector has lacked a robust definition of “core values, an explicit set of shared beliefs and philosophical foundations upon which they can be built” (Warriner, 2010, p. 15). In addition, these organisations have inevitably been situated within the larger framework of service organisations, including the history and traditions of relationships with other organisations, government agencies, funding bodies and local communities; all of which have had significant influence over the evolution of the sector (Davis & Ashton, 2001; Harrison, 2010; MHAC, 2008; Mental Health Commission, 1998; O'Brien et al., 2009; Warriner, 2010).

As mentioned previously, recent policy efforts, including a greater emphasis on responsiveness to service users, their well-being and aspirations (*Central Potential*, 2008; Ministry of Health, 2005; Mental Health Commission, 2007b), appeared to signal the need for organisational change in the mental health sector. On the surface, these would appear to have heralded a unique niche for the community NGOs. But just how such a sector transformation might be achieved has generated considerable debate, in which community organisations have had to navigate powerful expectations and priorities imposed by funders and clinical service providers (Frumkin & Clark, 2000; Harrison, 2010; *Platform Trust*, 2008; Warriner, 2001, 2010). Inevitably, these pressures have required considerable manoeuvring as the NGOs have struggled to avoid compromising their own ideals (Ganesh, 2003, 2005). This, in turn, has affected the capacity and direction of organisational change, the enacting of a valued identity and the establishment of a unique niche for the community sector.

Barriers to recovery-oriented services, organisational change and sector transformation

Scholars and other commentators have identified many barriers to recovery within current mental health services (Bonney & Stickley, 2008; Lapsley & Nikora, 2002; O'Hagan, 1999; Perkins & Repper, 2013; S. Rose, 2000). These have included paternalistic and coercive treatment systems (Edgley, Stickley & Masterson, 2006; O'Brien & Golding, 2003; Pescosolido et al., 1999; Mancini et al., 2005); indifferent professionals and the negative side effects of medication (Chamberlin, 1998; Mancini et al., 2005), and widespread stigma evident in both services and communities (Bonney & Stickley, 2008; *Central Potential*, 2008; Chamberlin, 1998, 2004; Sayce, 2000; Salyers, 2007). Furthermore, the systemic decontextualisation of people's experiences within services, especially clinical services, has not only increased their vulnerability to psychological distress, but also their susceptibility to "physical illness, a shorter lifespan, under-employment, poor relationships and lower psychological resilience" (*Central Potential*, 2008, p. 11).

In addition, Mary O'Hagan (2004, 2009b) has noted that multiple versions of recovery discourses have been operating within mental health systems worldwide. She, and others, commentators have referred to the equation of rehabilitation with recovery as the watered-down version, and has confined organisational practices to ameliorating symptoms and helping people overcome functional limitations *despite* their disability (Curtis, 1997; Deegan, 1988; O'Hagan, 2008, 2009b; Pearson, 2000; Swarbrick, 2006). This version has focussed on individuals learning to manage stress more effectively, become less vulnerable to illness and better able to cope through developing social competence or "independence" (Curtis, 1997; Fisher, 1994; Jacobson & Curtis, 2000; O'Hagan, 2004, 209b, Swarbrick, 2006).

Many advocacy groups have also expressed alarm about the incompatibility between the recovery vision, and acceptance of the use of force in treatment services (Anthony, 2006; Lord & Dufort, 1996; Minkowitz, 2006; O'Brien & Golding, 2003). They been angered that, despite widespread concern about all forms of coercion in psychiatry, the legitimation and authority of the medical model has provided an agenda for coercive treatment (Anthony, 2006; Chamberlin, 1998; Golding, 2003; Lord & Dufort, 1996; Minkowitz, 2006; O'Brien et al., 2003; Pescosolido et al., 1999). Although, Anthony (2006), among others, has argued that there can be no such thing as "forced recovery" the professional literature has rarely acknowledged the issue of iatrogenic harm and compulsory treatment has remained a feature of Western mental health systems (Anthony, 2006; Breggin, 1993; Chamberlin, 1998; Edgley et al., 2006; Grob, 2004; Minkowitz, 2006; Pescosolido et al., 1999).

However, perhaps the most important, barrier to establishing a recovery orientation in organisational practices has been the inevitable influence of extra-organisational forces, which transcend organisational boundaries and facilitate the transfer of ideas, rationalities and norms throughout an organisational field (DiMaggio & Powell, 1983, 1991; Lammers, 2011; Reay & Hinings, 2005; Scott, 1991). These constructions become embedded in organisational realities and display discursive and regulatory continuity over time and space (Creed et al.,

2002; DiMaggio & Powell, 1983; Foucault, 1978; Powell & DiMaggio, 1991; Scott, 2001). Scholars have referred to this process of creeping uniformity, the spread of particular ideas and practices throughout an organisational field, as institutionalisation (DiMaggio & Powell, 1983; Leclercq-Vandelannoitte, 2011; Meyer & Rowan, 1977).

Issues of institutionalisation, and institutional change, underpin my second and third research questions because the degree to which mental health organisations participate in, and identify with, naturalised discourses may be significant barriers in their efforts to become recovery oriented. In the next section, I examine evidence that suggests the mental health sector has been, and continues to be, institutionalised and the implications this has had for embedding a recovery-orientation in mental health organisations.

Institutions: Persistence, legitimacy and change

Institutional logics can be seen as the critical link between organisational communications and practice (DiMaggio & Powell, 1991; Lammers, 2011; Reay & Hinings, 2005). This has been particularly important for the community organisations, where there are explicit tensions between organisational ideals and values with the expectations of society, and more powerful organisational arrangements (Fakhoury & Priebe, 2007; Frumkin & Galaskiewicz, 2004). A critical discussion of institutional dynamics is included here, rather than in the problematic of organising and society, because institutionalised discourse and practices are expressed in organisational rationalities, stories and communication practices (Broadfoot & Munshi, 2007a, 2007b; Creed et al., 2002; Mumby, 1987; Weick, 1995, 2005). It is through these processes that dominant ways of thinking and acting become established, naturalised and persistent (Barley & Tolbert, 1997; Lammers et al., 2003; Powell & DiMaggio, 1991; Scott, 2001; Suddaby, 2006). It is this everyday ordinariness that is most relevant to this research question. However, it is also in everyday, organisational practice that the spaces for resistance, disruption and the destabilisation of institutional authority emerge (Ashcraft & Pacanowsky, 1996; Holmer-Nadesan, 1996; Maguire & Hardy, 2009; Mumby, 2005; Trethewey, 1997).

Much previous scholarship on institutional work has focussed on the establishment and maintenance of institutional legitimacy (Barley & Tolbert, 1997; Lawrence & Suddaby, 2006; Philips et al., 2004; Scott, 2001), rather than a critical examination of how alternative discourses, new actors and new subject positions might emerge to bring about organisational or systemic change (Deetz & Mumby, 1990; Maguire & Hardy, 2009; Reay & Hinings, 2005; Seo & Creed, 2002). The conventional body of institutional literature has produced many descriptive accounts of institutionalised behaviours and how these are embedded and have endured across organisations (Barley & Tolbert, 1997; Baum & Oliver, 1996; Douglas, 1986; Jepperson, 1991; Lammers, 2011; Meyer & Rowan, 1977, 1991; Scott & Meyer, 1994). But, this scholarship doesn't appear to have taken the next, critical step and investigated the ways in which institutions represent powerful and privileged interests that have worked to resist challenges and disruptive practices that might destabilise that power (Maguire & Hardy, 2009; Mumby, 1988) .

Critical scholars, therefore, have gone beyond mere descriptions of institutionalised practices as habits and routines, and explored how these have been instrumental in maintaining and privileging the interests of some groups and generally determining "the way things are done around here" (Barley & Tolbert, 1997; Latour, 1987; Maguire & Hardy, 2009; Mumby, 2008; N. Rose & Miller 1992).

The fundamental characteristics of institutions

The basis of institutionalism is the proposition that under certain circumstances organisations will come to resemble one another in their structures and practices due to a host of pressures acting on them collectively. This is referred to as institutional isomorphism (Barbour & Lammers, 2007; DiMaggio & Powell, 1983, 1991; Meyer & Rowan, 1991; Mizruchi & Fein, 1999). New institutional theory has emphasised the quest for organisational legitimacy as the basis of such organisational behaviour (Ganesh, 2003; Golant & Sillence, 2007; Meyer & Rowan, 1991; Scott, 2008) rather than simple resource

dependency as the driver of conformity for organisations within an organisational field (Pfeffer & Salancik, 1978).

John Lammers (2011) has argued that institutional logics function as patterns of rules that provide the conceptual and empirical link between the “predominantly macro world of institutions and the micro world of organisational communication” (p. 154). In addition, scholars have been concerned to incorporate within the notion of institutions, “all of the buildings, technologies, social arrangements, as well as the range of discursive practices accessed by those within a particular field” (Deetz, 1992, p. 126). The distinction is important, especially for the mental health field where, typically, institutions have been thought of as primarily material i.e. large facilities or hospitals on the outskirts of towns.

In other words, commentators other than institutional scholars are now recognising that “institutionalisation is not only about the buildings and locations; it is about how things are done, how support is provided, who gets to choose and who has the power” (Johns, 2010, p. iv). They represent, therefore, powerful mechanisms for social control and have proved to be much more persistent, “insidious and pervasive than mere buildings” (Johns, 2010, p. iv).

Defined in terms of both their material and symbolic formations, institutions share several important features. First, they advantage people who are already powerful in society and enable them to control access to roles and positions that place them in inequitably strong positions to influence the construction of organisational realities (Deetz & Mumby, 1990; Deetz, 1992; Hwang & Powell, 2009; Scott, 2008). This has been achieved largely through institutional control of professional training and accreditation.

Second, through their professional bases and presence in academic inquiry, institutions produce and control the legitimate “body of knowledge” for an organisational field (Scott, 2008). This has meant that alternative ways of knowing or explanatory models have struggled to gain traction (Broadfoot & Munshi, 2007a). Third institutions have powerful implications for organisational

behaviour and conformity (Barbour & Lammers, 2007; Barley & Tolbert, 1997; Di Maggio & Powell, 1983, 1991; Treichler, 1987; Zorn et al., 2011).

Reay and Hinings (2005) have noted that, central to institutional theory, are the powerful mechanisms through which institutions act to maintain the status quo, and to restore stability to perturbations in an institutional field. In particular, organisations experience pressure to conform to institutional beliefs and practices because there are significant costs for non-compliance (DiMaggio & Powell, 1983; Meyer & Rowan, 1977, 1991; Selznick, 1984, 1996). This has enabled institutions to establish relationships of dependence, among groups with differing goals and interests, who are competing for access to finite resources (Barley & Tolbert, 1997; Davis & Ashton, 2001).

According to Maguire and Hardy (2009), the persistence of an institution relies on the interconnected stability of three interlocking aspects or pillars “through which legitimacy is established and conformity secured” (p. 149). These constitute the regulatory, cognitive and normative components of organisational life (Maguire & Hardy, 2009; Oliver, 1992; Scott, 2001, 2008). Whether working separately, or in conjunction, the pillars of institutionalisation represent environmental pressures that work to produce homogeneity across organisations (Hoffman, 1999; Powell & DiMaggio, 1991; Scott, 2008; Wicks, 2001). DiMaggio and Powell (1983), who described this process of homogenisation as isomorphism, argued that it is not a rational pursuit but rather a perceived need for political or social legitimacy.

Therefore, despite being downplayed by subsequent institutional scholars (Mizruchi & Fein, 1999), DiMaggio and Powell, (1983, 1991) recognised from the first, that the exploitation of power, or coercion, is a critical aspect of isomorphism and organisational control. It is only recently, however, that a critical lens has been applied to the study of institutional dynamics, particularly the destabilisation of institutional power and legitimacy (Caronna, 2004; Lawrence et al., 2011; Lounsbury, 2009; Maguire & Hardy, 2009; Mizruchi & Fein, 1999; Mumby, 2008; Phillips et al., 2004).

Institutional persistence and the institutional pillars

Most contemporary scholars agree that institutional persistence, and the similarity of organisational forms, behaviour and communicative practices is less about the rational pursuit of operational efficiency, and more about the adoption of institutional strategies, structures, and processes to ensure organisational credibility and survival (Barbour & Lammers 2007; Ganesh, 2003; Meyer & Rowan, 1977,1991; Noir & Walsham, 2007; Powell & DiMaggio, 1991). Organisational behaviours may be subject to the authority of one institutional pillar (Hoffman, 1999; Scott, 2001, 2008); or involve the interaction of all three at a given place and time (Wicks, 2001).

The legislative pillar of an institution refers to the various regulatory frameworks that confer authority on specified agents (including organisations, administrative agencies and government bodies) to formally constrain behaviour, establish rules, police conformity and, if necessary, coerce compliance (Caronna, 2004; Maguire & Hardy, 2009; Meyer & Rowan, 1977, 1991; Scott, 2001). For example, regulatory pressures have increased standardisation in mental health NGOs who are required to adopt institutionalised discourses, rules and procedures in order to preserve their legitimacy and funding streams (Golant & Sillence, 2007; Scott, 2008; O'Brien et al, 2009; Frumkin & Galaskiewicz, 2004; Ganesh, 2003). Legislation and regulation have, therefore, directly shaped organisational forms, and their accountability to other stakeholders (Zorn et al., 2011), and seriously compromised the capacity of these organisations to determine and manage their own affairs and develop a unique and independent identity (Ganesh, 2003; O'Brien et al, 2009).

Regulation, however, is founded on rationales that draw on particular, and legitimised, bodies of knowledge; articulating the vocabularies in which issues can be reasoned and argued about (Latour, 1987; Miller & O'Leary, 1987; Miller & N. Rose, 1988; S. Rose & Black, 1985, 1988). These, then, form the interwoven discursive arrangements of bodies of knowledge, which form the cognitive pillar of an institution (Maguire & Hardy, 2009). Nelson Phillips and his

colleagues (2004) noted that it is these discursive aspects that bind institutional knowledge, structures and action into conventions that become self-policing.

The strength of the cognitive pillar refers to the coherence of its knowledge bases and discourses (Fairclough, 1993; Caronna, 2004; Oliver, 1992; Maguire & Hardy, 2009). In other words, the capacity of an institution to endure is less dependent on the mere accumulation of its texts, but rather the extent to which these texts and discourses present a structurally unified perspective that then becomes reified and taken for granted (Maguire & Hardy, 2009; Phillips et al., 2004). In this way, the orthodoxies of rationalities and meanings are created from interdependent collections of texts, produced and distributed by particular, and powerful, discourse communities (Phillips et al., 2004; Fairclough, 1992; Maguire & Hardy, 2009).

Texts produced by professionals, and shaped by their institutional repertoires, represent an “order of discourse” (Fairclough, 1993, p. 135); they reinforce dominant rationalities and claims of expertise through referencing the “archaeology” of this knowledge (Foucault, 1972; Mumby, 1988; Phillips et al., 2004). Accumulated texts create a coherent body of institutional knowledge when they converge in their descriptions and explanations of social “realities” such as mental illness (Phillip et al., 2004). Similarly, organisational and professional practices are reproduced when institutional texts draw on and reinforce each other in well-established ways.

Institutional control of dominant discourses, through the production of texts, has therefore determined the prevailing orthodoxy (Hoffman, 1999; Phillips et al., 2004; Scott, 2001). Biomedicine, for example, has created a highly structured and coherent body of knowledge because the biomedical professions control the production of, and access to, expertise and knowledge (Bracken & Thomas, 1999; Maguire & Hardy, 2009; Mumby, 1988). In addition, the professions and associated groups have built common vocabularies, concepts and terms of reference that have maintained and privileged their perspectives of the world, while excluding others outside the professional enclave (Fairclough, 1992; Foucault, 1970, 1972; Koenig, 2000; Lord & Dufort, 1996; O’Hagan, 1994,

1999; Pearson, 2004). As Peter Miller and Nikolas Rose (1988) contended, the “mental lives of citizens, their emotions, capacities and propensities have become subject to new forms of expert knowledge and professional engineers of the soul”(p. 171).

Critical scholars have noted that the routine transfer of institutional discourses and practices throughout an organisational field, such as mental health, has enabled control at a distance of organisational communication and practices (Hoffman, 1999; Hoffman et al., 2002; Mumby, 2008; Reay & Hinings, 2005; Scott, 2008). In this way, normative institutional pressures have established the behaviour of organisations through the naturalisation of societal expectations, norms and moral obligations (Deetz & Mumby, 1990; Foucault, 1973a; Mumby, 1997; Sillence, 2001). The normative pillar of an institution, therefore, has encouraged conformity by determining and monitoring what is considered appropriate practice (Maguire & Hardy, 2009; Wicks, 2001; Caronna, 2004; Hoffman et al., 2002; Scott, 2001; Wicks, 2001).

Normalised discourses and conceptual frameworks are embedded in organisational and national policy frameworks, strategic plans and service specifications (Cheney et al., 2004; Kline, 2006; Philo, 1996). People employed in an organisational field are formally socialised into normative discourses and practices through training in their profession, orientation into organisational cultures, or more informally through professional associations, conferences, and publications (Ganesh, 2003; Greenwood et al., 2002; Zorn et al., 2011). Historically, in mental health organisations, normative institutional power, as well as legislative power, has mandated professional standardisation. This has led to the naturalised assumption that “professionals know best” (Alvesson & Willmott, 2006; Bracken & Thomas, 1999; Foucault, 1972, 1973; Scott, 2008).

Globally, particular configurations of organisational knowledge and practices in mental health services have prioritised certain organisational activities; while others, that might support alternative discourses such as recovery, have been precluded or devalued (Alvesson & Willmott, 2006; Maguire & Hardy, 2009; Oliver, 1992; Philips et al., 2004). The growth of institutionalised

managerialism, for example, in healthcare environments has promulgated the spread of evaluative and normative standards such as an insistence on accountability and outcomes measurement (Alvesson & Willmott 2006; Hwang & Powell, 2009; Mizruchi & Fein, 1999). Other managerialist values such as “efficiency” and “quality” management have, also, increasingly permeated organisational cultures and discursive practices in public health systems (Lammers et al., 2003; Zorn et al., 2011).

Many critics have warned, however, that these forms of “accounting” have reduced knowledge and practices to standardised actions, the efficacy of which then becomes unquestioned (Scott, 2008; Suddaby & Greenwood, 2001). An important consequence has been the increasing propensity of market-based discourses and rationale in health services alongside correspondingly narrow expectations of market based solutions to organisational issues (Ganesh, 2003).

The institutions and non-government organisations: The costs of non-compliance

Institutions have well developed mechanisms, routines and ritualised responses that associate non-conformity with increased “costs” in different ways (Jepperson, 1991; Reay & Hinings, 2005). These represent various forms of generalised, defensive work that institutions employ as they adjust to and absorb perturbations in the organisational field. Non-compliance has generally created significant economic risk for organisations, not only directly in terms of resources but also in terms of reduced legitimacy and access to the resources that come with legitimacy (Ganesh, 2003; Philips et al., 2004). Publicly funded organisations have tended to be especially susceptible to institutional pressures, and this vulnerability has limited their ability, for example, to act as advocates for social or policy change. Therefore the notion of their organisational independence has largely been a “myth” (Ganesh, 2005).

There are also costs for non-compliance with the cognitive pillar of institutional authority. This has meant that establishing and championing alternative discourses and practices, creating new ways of thinking and

“publishing” new texts has required considerable, strategic effort (Maguire & Hardy, 2009; Sillence, 2007; Seo & Creed, 2002). These difficulties have also contributed to the naturalisation of organisational talk and behaviours that express narrative coherence, rather than more maverick reflections of organisational reality. Alternative narratives and explanatory models are thus obscured or made to seem implausible (Prichard, 2005).

Managing issues of compliance and competing accountabilities, have been particularly difficult for healthcare organisations positioned as subordinate to, and dependent on, institutionally powerful clinical services. Their ability to remain accountable to their constituents, demonstrate their effectiveness and advocate for alternative approaches, has frequently been compromised by the expectations and requirements of these more powerful organisations (Ganesh, 2003; Stewart, 2007). In many cases, subordinate organisations have struggled to command alternative discourses, such as recovery, and have had to make strategic compromises such as the adoption of market, managerial and clinical vocabularies, rather than resist or challenge these (Ganesh, 2003, 2005; MHAC, 2008; Stewart, 2007; Tennant et al., 2008). This has frequently led to these organisations becoming “more concerned with justifying [their] own existence than in serving the public good” (Ganesh, 2003, p. 568).

Institutional literature has tended to be preoccupied with how communications and behaviours are embedded and endure across organisational fields (Barley & Tolbert, 1997). In contrast, institutional change requires significant disruption of institutional thinking and practices before alternative explanatory models, meanings, discourses and texts can become established (Colomy, 1998; Maguire & Hardy, 2009; Oliver, 1992; Scott et al., 2000; Seo & Creed, 2002). Destabilising institutional arrangements requires concerted and strategic challenges by multiple stakeholders, in order to be effective and sustainable (Maguire & Hardy, 2009; Scott et al., 2000; Seo & Creed, 2002; Sillence, 2001; Tolbert & Zucker, 1983).

Institutional disruption and destabilising the institutions

Instigating transformative, sustained institutional change is difficult (Freire, 1970; C. Oliver, 1992; Maguire & Hardy, 2009). Little scholarly attention has focussed on the conditions or processes of deinstitutionalisation (Clemente & Roulet, 2015; Maguire & Hardy, 2009; Lawrence & Hardy, 2004; Lawrence & Suddaby, 2006; Reay & Hinings, 2005; Scott et al., 2000). Typically, it has been less powerful, or marginalised, groups whose interests are misaligned with existing rules, structures and practices that have attempted to disrupt institutional arrangements. But there has been even less academic focus on what happens when institutional outsiders attempt to establish alternative discourses and bring about organisational and social change (Cooren, 2001; Maguire & Hardy, 2009). In addition, there has been little research, theoretical or empirical, that has investigated how institutions respond to alternative discourses and engage in defensive institutional work (Maguire & Hardy, 2009; Oliver, C., 1992).

The first challenge for destabilisation of the institutional pillars, therefore, has been to problematise current institutional practices, meanings and interpretative closure (Maguire & Hardy, 2009; Mumby, 1997, 2005, 2008; Oliver, 1992; Prichard, 2005; Zorn et al., 2000). Second, a major contextual or environmental change (Freire, 1970; Maguire & Hardy, 2009; Zoller, 2011) such as a public inquiry can be influential in initiating disruption of institutionalised practices and thinking.

However, causal links between public inquiries, institutional change and social policy reform have been notoriously difficult to attribute and, in general, government inquiries have tended to “support the legitimacy of social institutions and extend the hegemony of prevailing system supportive ideologies” (A. Brown, 2000, p. 48). Other scholars have described them as last resort ceremonies (Emerson, 1981) and ritual cleansings (Prichard, 2005), which have reinforced dominant perspectives by offering ideologically acceptable interpretations of events that reassert the legitimacy of social institutions (A. Brown, 2000, 2004; Meyer & Rowan, 1977; Prichard, 2005; Suchman, 1995).

All of this has meant that the most significant issue for institutional, and thereby organisational, transformation has been making the discourses of change “stick”. Embedding systemic organisational change means new discourses have to, not only successfully compete with more dominant discourses, but become stable and normalised at a social level (Maguire & Hardy, 2009; Reay & Hinings, 2005; Zald & Berger, 1978; Zoller, 2005; Zoller & Fairhurst, 2007).

These difficulties have meant that organisational change efforts, have typically been local, situated and framed as resistance (Cheney et al., 2004; Cheney & Cloud, 2006; Mumby, 1997). Through such efforts, less powerful groups have endeavoured to create organisational spaces where meanings become contestable and alternative possibilities for action emerge (Alvesson et al., 2008; Cheney et al., 2004; Holmer-Nadesan, 1996; Morrill et al., 2003; Mumby, 2005).

However, the efficacy of resistance efforts has been contingent on the capacity of individuals, or groups, to engage strategically with alternative discourses, establish new subject positions and produce new texts that challenge the privileged position of stakeholders in the dominant system (Holmer-Nadesan, 1996; Mumby, 2005; Zoller & Fairhurst, 2007). Dennis Mumby (2005), for example, has warned that many acts of resistance become mere reactivity when no alternative explanatory models are framed or explored.

Maguire and Hardy (2009) made a useful distinction between *insider* and *outsider* initiated change efforts in order to explain the apparent lack of effective, substantive institutional change. They defined insiders as organisational actors who are embedded within a field and who, therefore, have limited agency but who also, at least to some extent, would be threatened by the abandonment of existing institutional knowledge or practices (Colomy, 1998; Lawrence & Suddaby, 2006; Morrill et al., 2003). In contrast, outsiders were defined as those for whom the status quo represented a threat or problem, and who are, therefore, more engaged with the benefits of change (Everett, 1994; Maguire & Hardy, 2009).

These distinctions are particularly important for people with lived experiences of serious psychological distress who have been relentlessly *outside* the dominant discourses of mental health and mental illness. Similarly, the community NGOs are also frequently in this position as they continue to advocate for their own niche, legitimacy and identity within the sector.

Insider-initiated change efforts

Changing systems from within has tended to favour gradual *evolution* rather than *revolution* and resulted in organisations being “restructured” rather than re-constructed, or transformed (Colomy, 1998; Everett, 1994; Maguire & Hardy, 2009). Therefore, these efforts have typically resulted in changes that are elaborative rather than reconstructive (Colomy, 1998). Institutional features such as knowledge bases, arrangements of power and privileged interests have remained intact (Hardy & Maguire, 2008; Maguire & Hardy, 2009).

Where such change efforts have been instigated they have generally been motivated by economic advantage, and powerful actors in privileged subject positions, who may do things differently or even shift roles, have remained dominant (Hardy & Maguire, 2008; Lawrence & Suddaby, 2006; Maguire & Hardy, 2009). In other words, insider efforts at institutional change have usually been framed merely as system improvements and have left powerful professionals as key policy and service change agents (Ashton et al., 2005; O’Hagan, 2009).

This kind of restructuring has been evident in Western mental health reforms over several decades, particularly with the shift to community-based services (Durie, 1999; Joseph & Kearns, 1999; Mason, 1996; Sullivan, 1994; van Hoof et al., 2000; Warren, 1997). The formal adoption of a recovery philosophy in Aotearoa\New Zealand mental health services also demonstrated some classic features of insider change efforts (O’Hagan, 2004, 2012; Pearson, 2002, 2004; Warriner, 2010). This has been particularly notable in the ways which the discourse of recovery has been implemented in service development and policy (Barker, 2003; O’Hagan, 2009; Pearson, 2000, 2004).

Similarly, Jan Wallcraft (2009), commented that proposed changes to the English system, and the drive to accommodate various interests has resulted in a diluted version of recovery that was limited to the ways in which mental health services could be improved and updated, but did not seriously challenge medical diagnostic and treatment concepts nor the systems and structures that supported their institutionalisation (Anthony, 1993; Banks et al., 2004; Barker, 2003; Becker et al., 1998; O'Hagan, 1999, 2004).

Notwithstanding the limited efficacy of insider change efforts (Lawrence & Suddaby, 2006; Maguire & Hardy, 2009) psychiatric orthodoxy has faced challenges to its legitimacy from “mavericks” inside psychiatry. As previously discussed, these insider activists have included, the anti-, critical- and post-psychiatry movements (Bracken & Thomas, 2010; Foucault, 1973a, 1973b; Pilgrim & Rogers, 2009). These mavericks have contested the authoritative legacy of theory and practice in mental healthcare worldwide (Frances, 2013; Kutchins & Kirk, 1997; Jureidini, 2012; Moncrieff, 2008; Mosher & Boyle, 2004). Bracken and Thomas (2001, 2010), important proponents of the post-psychiatry movement, commented that “by challenging the notion that psychiatric theory is neutral, objective, and disinterested, post-psychiatry [has weakened] the case for medical control of the process” (p. 726). This has led other academic psychiatrists to conclude that psychiatry can no longer claim a privileged position in mental health care (Bracken & Thomas, 2005; Pilgrim, 2007).

However, in practice, this claim seems to be premature (Argyle, 2005; Frances, 2013; Mountain & Shah, 2008; Moncrieff & Crawford, 2008; Pilgrim, 2007). Many scholars, concerned that insider reforms typically leave powerful interests in place, have noted the risks in attempting to enable social change by engaging with what already exists (Maguire & Hardy, 2009; Mumby, 2005). Heather Zoller (2011), among others, has been wary of challenges to health discourses that have failed to address the social and political roots of health disparities and have tended to protect vested interests. Reay and Hinings (2005) have also argued that insider efforts may disrupt the coherence of a discourse; but with no change in institutional structures, frequently leave the same actors

guiding policy and strategy (A. Brown, 2000, 2004; Maguire & Hardy, 2009; Pilgrim & Rogers, 1999; Prichard, 2009).

Therefore, champions of marginalised, vulnerable and *dis*-abled groups throughout the world have called, not for improvements in existing services, but changes in control and leadership leading to organisational transformation (Chamberlin, 2004; Deegan, 1996; O'Hagan, 2009c; Oliver, 1998; Pearson, 2002; Warriner, 2009). These aspirations are typical of outsider change initiatives.

Outsider-initiated change efforts

Outsiders to institutionalised paradigms in mental health systems, have included service users, people with experiences of psychological distress, activist groups such as the psychiatric survivor movement (Chamberlin, 1988; O'Hagan, 1991; Warner, 2004) and, more widely, the community NGOs (Harrison, 2010; McMorland et al., 2008; O'Brien et al., 2009; Warriner, 2001). These have all been positioned as, both, outsiders and potential change agents (Everett, 1994; Freire, 1970; Morrison, 2006; Seo & Creed, 2002). Although there has been limited scholarly attention to outsider efforts at institutional change, commentators have agreed that outsider driven disruption has more potential for organisational transformation because the proponents are more engaged with the possible outcomes (Chamberlin, 2004; Lawrence & Suddaby, 2006; Maguire & Hardy, 2009; O'Hagan, 2009c; Seo & Creed, 2002).

Maguire & Hardy (2009) have described outsider change efforts as strategies for problematising and disrupting institutional discourses in the attempt to establish distinct, alternative explanatory models (Farjoun, 2002; Lounsbury, 2001; Maguire & Hardy, 2009; Phillips et al., 2004; Zilber, 2002). These outsider driven efforts have also been characterised by the emergence of new subject positions where people speak out and act in support of problematisations that challenge the discourses about institutionalised practices (Maguire & Hardy, 2009; Seo & Creed, 2002).

Outsider change efforts have, typically, relied on the breakdown of both the structure and coherence of institutional arrangements so that existing

practices are no longer “taken for granted” and become negotiable. Subsequently, if successful, outsider discourses offer credible alternatives to the status quo and are absorbed, coherently into new texts. In successful “deinstitutionalisation”, the problematisations have become normalised in new bodies of scientific, lay, and legal knowledge. Within the international mental health sector, for example, service user groups and organisations, such as ANOPS in this country, created new texts. These were initially based on personal accounts and narrative resistance (Warner, 2004; Weick et al., 2005) and eventually became an alternative discourse of recovery that, in Aotearoa\New Zealand at least, has been formally incorporated into national policy (Mental Health Commission, 1998). Similarly, new subject positions, the cause as well as the consequence of collective activism (Morrill et al., 2003; Zoller, 2005), have emerged; the most significant in this country being the establishment of the Mental Health Commission (Leibrich, 1998; Mason, 1996; Mental Health Commission, 1998; O’Hagan, 1991, 1999)

Scholars have generally correlated the efficacy and sustainability of outsider change efforts with the degree to which they have been able to establish and defend alternative discourse and practices from criticism and derision (Maguire & Hardy, 2009; Sillence, 2001). This has meant that the legitimacy and sustainability of alternative models has depended on the “publishing” of accounts that support problematisations and offer credible alternatives. Their effectiveness depended on such factors as the editorial policies of academic journal editors (Craddock et al., 2008; Kecmanovic & Hadzi-Pavlovic, 2010; Koenig, 2000; Moncrieff & Crawford, 2008; Pincus et al., 1993) and the mainstream media (Nairn, 1999; Philo, 1996). Outsiders have also had much greater difficulties gaining access to research funding (Duncan et al., 2004). In summary, unless an alternative discourse is established and reinforced, systems inevitably revert to the status quo (Czarniawska & Wolff, 1998; Hinings & Greenwood, 1988; Maguire & Hardy, 2009; Oliver, 1992).

Some scholars have noted that the ways that institutions have typically worked against change and responded to threats to their status and legitimacy

has been under researched (Lawrence & Suddaby, 2006; Suchman, 1995). Maguire and Hardy (2009) have referred to these efforts as defensive institutional work, and they distinguished between generalised, insider engagements with the “routines and rituals of reproduction” (p. 169) and more direct and particular forms of defence. They noted that the disruptive efforts of outsiders have typically provoked defensive reactions from institutional insiders with the resources, networks and social sanctions to mount strategic and forceful counter challenges (see also, Czarniawska-Joerges & Wolff, 1998; Mumby, 1997; Seo & Creed, 2002).

Velvet gloves and iron fists: Defensive institutional work

Substantive organisational change is difficult to embed and institutional defensive work helps explain the continuing influence of previously dominant institutional logics (Reay & Hinings, 2005). It is probably the major barrier to organisational transformation, in Aotearoa\New Zealand mental health services, as elsewhere (Barber, 2005; Fougere, 2001; Gawith & Abrams, 2006; O’Hagan, 2009; Pearson, 2004; Wallcraft, 2009). Understanding defensive institutional work therefore, is important for investigating both the adoption of *new* organisational practices and the abandonment of *old* ones (Maguire & Hardy, 2009).

Radical institutional change requires disruption to both the structure and coherence of institutional logics (Maguire & Hardy, 2009; Reay & Hinings, 2005). Although the problematisations and disruptions, typical of insider change efforts, may lead to changes in the coherence of discourses, they do not necessarily affect the material or structural arrangements of institutions. Therefore, the system invariably restores itself to some form of the status quo (Maguire & Hardy, 2009; Reay & Hinings, 2005). Reay & Hinings (2005) have maintained that, despite the concept of isomorphism being central to institutional theory, little attention has been paid to this recomposition phase of institutional change.

Defensive institutional work, for the purposes of analysis, can be usefully separated into two types; one the more generalised, habituated institutional

responses to organisational non-conformity and the other more direct, particularised reactivity to perceived threats to institutional authority. The former, for example, might include discursive accommodations such as the translation and absorption of alternative discourses, a theme that will be developed in the next section. Particular defensive counter challenges to perceived threat, however, can be overt and strategic. For example, these often include attacking the credibility and “reasonableness” of opponents (Maguire & Hardy, 2009; Weaver, 2010), or are somewhat subtle: like an increasing focus on “dangerousness” and “risk” (N. Rose, 1998; Sawyer, 2005; Szmukler & N. Rose, 2013; Zoller, 2012). Other strategies have been evident in a clinical “backlash” to recovery in mental health. For example, there have been frequent appeals to the “responsibility of clinicians” (Argyle, 2005; Craddock et al., 2008; Mountain & Shah, 2008), the “expectations of the community”, and “public safety” (Edgley et al., 2006; Fisher, 1994; Grob, 1995; O’Brien & Golding, 2003; N. Rose, 1998).

Particularised defensive institutional work: Reacting to threat

Maguire and Hardy (2009) have maintained that particular defensive institutional work is typically directed at outsider-initiated acts of dissent and disruption. Defensive efforts, therefore, have tended to be directed at countering assertions of the negative impacts of institutional practices, disputing problematisations and claims of unethical, undesirable and inappropriate behaviours while vigorously challenging the need for institutional or professional regulation.

Systemic change has been thwarted by a, perhaps predictable, backlash from orthodox psychiatry, with many scholars vigorously defending the professional authority and status of psychiatry (Argyle, 2005; Craddock et al., 2008; Holloway, 2008; Koenig, 2000; Mountain & Shah, 2008; Oyeboode, 2008). Despite the many documented failures of biomedical psychiatry, Craddock and colleagues (2008), for example, documented widespread professional anxiety about the “creeping devaluation of medicine” which, they claimed, was “very damaging to both the standing and understanding of psychiatry in the minds of the public” (p. 6). And yet, as Moncrieff and Crawford’s (2001) study of 20th

century British Psychiatry demonstrated, alternative models of treatment and care have actually made few inroads into biomedical dominance; in fact, there appears to be an increased engagement with conventional scientific pursuits such as psychopharmacology, biotechnology and behavioural genetics has actively worked against change (Drake et al., 2003; Rogers, 2009; Pilgrim, 2007; Shorter, 1997).

Similarly, these cognitive defensive tactics have also ensured that professional “experts” have also directed the research agenda through control of the allocation of resources, the determination of what constitutes legitimate inquiry, the capacity to interpret research findings and the authority to influence how these are acted on (Reay & Hinings, 2005). Unsurprisingly, therefore, mental health research has continued to favour biomedicine and “evidence based” practices (Bonney & Stickley, 2008; Farkas et al., 2005; Manderscheid, 2006) while the editorial policies of academic journals can be seen to have encouraged the continuous, systemic production and reproduction of biomedical bodies of knowledge (Broadfoot & Munshi, 2007a; Kecmanovic & Hadzi-Pavlovic, 2010; Moncrieff & Crawford, 2008; Pincus et al., 1993). Similarly, clinical professionals have largely informed the development of mental health policy, and this has resulted in changes that have ultimately been “system confirming rather than system changing” (Prichard, 2005, p. 108).

Exploitation of the tactics of power associated with *non-compliance* is perhaps the most overt defensive mechanisms employed by institutional agents within an organisational field (Scott, 1990; Seo & Creed, 2002). For example, in the Aotearoa\New Zealand mental health sector, powerful interests have been able to manipulate funding vulnerabilities embedded in contracting processes and service specifications, thereby further decreasing the viability and legitimacy of the NGO sector (Harrison, 2010; McMorland et al., 2008; O’Brien et al., 2009; Warriner, 2010).

An increasingly evident defensive institutional strategy in the mental health field, as elsewhere, has been the establishment of the discourses of “risk”. Pilgrim and Rogers (2005) have cautioned that risk has become a socio-cultural

referent that has “peculiar expression in the mental health field” (p. xiv) and has enabled negative representations of serious psychological distress and myths of dangerousness to be perpetuated (Nairn, 1999; Robertson, 2000; N. Rose, 1998; Szmukler & N. Rose, 2013). Increasingly, established managerial discourses of organisational risk (Beck, 1992; Hamilton et al., 2007; Zorn et al., 2000) have combined with notions of clinical risk to re-gather the spectrum of mental health organisations under institutional control (MHAC, 2008; N. Rose, 1998; Sawyer, 2005; Shepherd, Boardman, & Slade, 2008; Szmukler & N. Rose, 2013). Nikolas Rose (1998) has argued that, in becoming central to discourses about the health of individuals, groups and communities, the organisational practices associated with risk have meant that “care and control have become inextricably linked in the community” (p. 179).

Orthodox risk assessment models, however, have typically ignored the political constructions of risk issues (A. Brown, 2004; Hwang & Powell, 2009; Zoller, 2011) and reinforced relationships of power through formally assigning the responsibility and accountability for managing risk to biomedical and managerial “experts”. This has, simultaneously, naturalised one-way communication from experts to lay citizens and excluded non-“experts” from the assessment and decision making around risk (A. Brown, 2000, 2004; P. Brown, 2007; Kinsella, 2004; N. Rose, 1998; Sawyer, 2005; Zoller, 2003).

Most significantly, the communication of risk within public forums, media, social policy and institutional texts has limited concerns to the “risks” mental health service users pose for others, and has ignored the very real risk to service users of treatment services themselves (N. Rose, 1998; Simpson, McKenna, Moskowitz, Skipworth, & Barry-Walsh, 2003; Szmukler & N. Rose, 2013; Teplin, 1985; Wilson, Nairn, Coverdale, & Panapa, 1999). Similarly there has been little scholarly attention, other than from those with lived experience of psychological distress, paid to people’s risks of victimisation, childhood trauma, and discrimination in the community (British Psychological Society, 2000; Lapsley & Yee, 2004; Leibrich & Carson, 2012; John Read, 2005).

All these phenomena make it important to understand how ideas, values and practices transfer discursively through an organisational field such as mental health, and whether these reinforce or challenge organisational legitimacy (Cooren, 2001; Creed et al., 2002; Golant & Sillence, 2007; Venuti, 2004; Zilber, 2002, 2006). Broad interpretative diversity (Zorn et al., 2000) and communicative strategies such as translation (Boxenbaum, 2006; Ganesh, 2010; Maguire & Hardy, 2009; Venuti, 2004; Weaver, 2010) and strategic ambiguity (Davenport & Leitch, 2005; Eisenberg, 1984; Jarzabkowski, Sillence, & Shaw, 2009; Markham, 1996) have arguably been the most influential in defensive institutional work.

In particular, it is the use of translation as a defensive institutional strategy that has most concerned commentators in the mental health field. As Mary O'Hagan (2009a) has argued, this has demonstrated “the power of mental health professionals and systems to colonise a concept so pervasively that the original owners of that concept are left invisible” (p. 20).

Generalised defensive institutional work: Translation, strategic ambiguity and other discursive strategies

Translation has increasingly replaced earlier notions of diffusion as an explanation of how ideas are transferred throughout an institutional field and as a mechanism for institutional defence work (Ganesh, 2010; Strang & Meyer, 1993; Venuti, 2004; Zilber, 2002, 2006). Maguire & Hardy (2009) have contended that the translation and *re*-translation of important concepts has been, perhaps, the most influential stratagem for maintaining control of institutional and organisational discourses in the face of challenge from institutional outsiders. This will be examined more fully in the problematic of voice, but what is important here is how the appropriation of important concepts from emerging discourses, such as recovery, creates new meanings and values that successfully resist any loss of institutional authority. In addition, as Reay and Hinings (2005) have argued, even where new institutional logics may arise, previously dominant logics will continue to be significant and influential, especially throughout the processes of translation (Maguire & Hardy, 2009).

Scholars have argued that alternative ideas are *translated* and *re-translated* by dominant groups; thereby becoming socially constructed as *new* knowledge according to prevailing orthodoxies and dominant perspectives (Cheney, 2000; Maguire & Hardy, 2009; Mizruchi & Fein, 1999; Venuti, 2004). Translations are then disseminated and systematically reproduced in institutional and organisational texts and practices (Cheney, 2000; Cronin, 2005; Venuti, 2004). Commentators have protested further that translation has meant that alternative discourses risk losing the conceptual energy with which they were infused by the people for whom they were originally of the greatest concern (Barker, 2003; Maguire & Hardy, 2009; O'Hagan, 2009; Wallcraft, 2009).

Additionally, the institutions of mental health have been able to maintain normative control of the discourses through the media, which has tended to privilege the opinions of dominant "experts" (Hazelton, 1997; Joseph & Kearns, 1999; Nairn, 1999; Philo, 1996; Seale, 2004). Such institutionalised expertism has also enabled institutions to avoid engaging with economic, social and political processes in favour of discrete, individualised interventions with readily measurable outcomes (Kendrick, 2012; Zoller, 2011).

As well as translation, other discursive strategies such as strategic ambiguity and discursive closure (Deetz, 1992), have exposed important texts to multiple interpretations and been seen to do generalised, defensive institutional work. Ambiguity has allowed convenient fictions about a unified view of social reality to be maintained. Multiple translations have been able to coexist and this has led to unintended, as well as deliberate, control of the discourses through strategic ambiguity (Cheney, 1999; Davenport & Leitch, 2005; Eisenberg, 1984; Markham, 1996; Mumby, 1997). For example, managerialist discourses have served as powerful rhetorical resources and organisations have been coerced into arguing for their legitimacy through the naturalised rationales of "value for money", "organisational quality", "cost effectiveness", "operational efficiencies" and other claims of the discursive territory (Alvesson & Willmott, 1996; Deetz, 1992; Harrison, 2010; *Platform Trust*, 2007, 2008; Warriner, 2010; Zorn et al., 2000). However, as Zorn et al. (2000) have commented, ubiquitous

managerialist “mantras” have been “simultaneously packed with and devoid of meaning” (p. 523). Similarly, in the mental health field “layers of subsidiary discourses” (Zorn et al., 2000, p. 518) such as “evidence-based”, “client-centred”, “recovery-oriented” and the quest for “independence” have become the guiding assumptions underpinning mental health discourses despite their conceptual ambiguity.

In the next section, I attend to the experiences of these people with lived experience of serious psychological distress, who have typically been the voices on the margins. Not only have they been excluded, as outsiders, from participation in the discourses of mental health and recovery but also the processes of citizenship (Chamberlin, 1998; Spandler, 2007; Sullivan, 1992; Ward, 2009; Ware et al., 2007). Their voices and subject positions, as institutional outsiders, are privileged here because they have generated the greatest potential for organisational transformation and the enactment of recovery in mental health services.

The problematic of voice in mental health organising

The problematic of voice, or the “crisis of representation” (Mumby & Stohl, 1996, 2007) has been particularly pertinent for people who are, or have been, users of mental health services and who have historically been unheard and excluded from participation in the decisions most affecting their lives (Carling & Allot, 1999; Carling et al., 1999; Rappaport, 1984, 1987, 1995, 2002; Sayce, 2000; S. Rose, 2000). Critical and postmodern scholarship has been intent to facilitate a wider range of voices and challenge the naturalised rules about who can legitimately construct organisational and social knowledge (Alvesson & Karreman, 2000; De Cock, 1998; Foucault 1982; Mumby & Stohl, 1996, 2007). These scholars have endeavoured to deconstruct inherent socio-cultural biases and extend theoretical reach in order to include and valorise perspectives other than those of dominant and powerful groups (Boje & Dennehy, 1993; Deetz, 2001; Cheney et al., 1996; Foucault, 1972; Ganesh, 2008). This problematic underpins the first and second of my research questions in examining which voices are heard in the construction of recovery discourses that influence

organisational communication and practices in the Aotearoa\New Zealand mental health sector.

Here I examine critical and postmodern scholarship that explores how ideas are transferred in social, organisational and institutional environments (Ashcraft & Pacanowsky, 1996; Venuti, 1992, 2004; Zilber, 2002, 2006) and how some voices are heard and others coerced or silenced (Broadfoot & Munshi, 2007a, 2007b; Gramsci, 1971; Mumby, 1997). The challenge for these scholars has been to circumvent dominant ways of seeing and thinking by including “voices on the margins” such as those of people with lived experience of psychological distress, their families and allies (Bracken & Thomas, 2001; Deegan, 1998; Leibrich, 2000a, 2000b; Mental Health Commission, 1996).

The crisis of representation

Researchers have argued that although the subjective knowledge of subjugated groups is not necessarily more *true*, these groups have been systematically voiceless and unheard (Deetz, 1992; Deetz & Mumby, 1990; Foucault, 1970, 1972; Mumby, 1988). The critical perspective, therefore, has been less concerned with defining what is, or is not, mental illness, and more about challenging the legitimacy of any group that claims to speak with exclusive authority about the truth of madness and distress (Bracken & Thomas, 2001, 2010; Foucault, 1973).

The socially and historically situated nature of language and power has been evident through the discursive history or “archaeology” (Foucault, 1972) of terms used to describe those designated or diagnosed with mental health problems. Powerful groups, such as psychiatrists have not only been able to label and define the terms of dominant discourses about mental health and distress, but they have also determined who can participate through control of access to information and the use of technical language that excludes non-members of their knowledge “class” (Cheney et al., 2004; Deetz, 1992; Rudge & Morse, 2001). It was not until the rise of the psychiatric survivor movement (Adame, 2006; Chamberlin, 1988; Cresswell, 2009; Everett, 1994; Morrison,

2006; O'Hagan, 1991), and popular, fictionalised and non-fictional accounts of life inside psychiatric hospitals and asylums (Frame, 1982, 1984; Kelsey, 1962; Leibrich, 1997; O'Hagan, 1994), that unease about professional interpretative power surfaced in the social imagination.

Such accounts have also increased awareness of the significance of language use in reflecting the values and assumptions of social groups and the organisations they establish (Broadfoot & Munshi, 2007b; Cheney, 2002; Gergen, 2001; Lakoff & Johnson, 1980). In the mental health field, many have echoed a Foucauldian stance in claiming that systems of representation and particular ways of specifying knowledge and truth go beyond the mere vocabularies of language use but, rather, become embedded and naturalised within social and organisational realities (Alvesson & Karreman, 2000; MHAC, 2008; Mumby, 2008). There has been growing unease, for example, with the use of professional language such as “non-compliant”, “lacking insight”, “inappropriate”, or “manipulative” within the context of relationships between people with lived experience of serious psychological distress and mental health workers (Ridgway, 2001). Groups such as the Mental Health Advocacy Coalition (MHAC) in Aotearoa\New Zealand (2008) have called for a new language for mental health; one that is not limited to expanding understandings of psychological distress, but also reflects people’s own explanatory models of their experience and anticipates their active participation as agents in their own recovery (Cresswell, 2009; Jacobson & Curtis 2000; MHAC 2008).

Working against change, however, have been social constructions of normality and deviance exacerbated by media representations that produce and reproduce overarching social narratives (Dutta & Zoller, 2008; Gwyn, 2002; Kline, 2003; Nairn, 1999; Seale, 2004). Most fictionalised accounts of “madness” have continued to be influential in constructing portraits of alienated freaks and villains (Seale, 2004; Wilson et al., 1999) and perpetuated myths of violence and unpredictability (Coleman, 1999; Leibrich, 1998; Nairn, 1999; Seale, 2004; Wilson et al., 1999).

Voices on the margins

Arana Pearson (2002), among others who have their own experiences of psychological distress, have highlighted the paucity of positive representation and their subsequent invisibility and powerlessness. Mental health “consumer” culture has filtered into the arts sector over time, with movies, literature, visual and performing arts becoming avenues for expression (Dellar et al., 2000; Frame, 1982, 1984; Kesity, 1962; Leibrich, 1997, 2000; Pearson, 2002); but Pearson and others have noted that people with lived experience of serious psychological distress are still not visible as community opinion leaders, nor meaningfully engaged with civic society, the business and media sectors (*Central Potential*, 2008; Chamberlin, 2004; O’Hagan, 2009c; Pearson, 2002; Warriner, 2009).

In addition, inequitable arrangements among discourse communities have limited the capacity of minority groups to set public agendas and frame debates (Zoller & Dutta, 2008; Zoller & Kline 2008). Such groups, for example the psychiatric survivor or consumer movements, have advocated strongly for their right to control the microphone and the importance of building a community of peers through the collective power of their stories (Adame, 2006; Lapsley & Nikora, 2002; Leibrich, 2000; Morrison, 2006; Warner, 2004). These endeavours to change the dominant discourse have, not only aimed at validating personal experience, but at creating the momentum and political power to change their social circumstances (McKnight, 1988; Zoller & Dutta 2008). In doing so these groups have endeavoured to win the public debates rather than engage with the medical or scientific ones (P. Brown et al., 2004; Zoller, 2012).

Advocates have championed the creation of alternative discursive spaces that facilitate empowering dialogue and allow marginalised groups and communities to articulate their own explanatory models of health and well-being (Adame, 2006; Broadfoot & Munshi, 2007a, 2007b; Rapp et al., 1991). In health promotion, for example, this has involved a sharp deviation from the traditional, top-down approach of public health campaigns towards the provision of spaces for marginalised groups to identify their own needs and formulate solutions to the issues they face (Alinsky, 1971; Dutta, 2007, Minkler, 1990; Rappaport 1995).

In addition, these groups have called for the transformation of service practices (Duncan et al., 2004; *Central Potential*, 2008; Kendrick et al., 2006; Ochaka et al., 1999; O'Hagan, 1999) to enhance people's capacity to determine their own life strategies according to their own understanding of their experience and health priorities (Dutta, 2007; Jacobson & Curtis, 2000; Rappaport, 1984, 1995; Zoller & Kline, 2008).

Despite these efforts, however, control of the discourses of health and illness have remained with medical professionals and orthodox biomedical science who have retained "naming rights" through the power to define and label experiences of "madness" through the processes of clinical diagnosis. This has meant that these experiences have continued to be represented as a wholly negative, deficit based experience with no legitimacy; valueless, demoralising, despairing, hopeless, chronic and dangerous (Leibrich, 1998; Mead, Hilton, & Curtis, 2001; O'Hagan 2009b; Read et al., 2004; Szasz, 1974).

The power of naming

Ludema, Wilmot, and Srivastva (1997) have argued that as professional disciplines emerged to diagnose and cure illness, the categorisation of illness and vocabularies of deficit were absorbed into the common language of everyday people. They have maintained, therefore, that the wider culture is taught how to *be ill*, how to recognise "illness"; speak about it and how to behave towards themselves and others in particular ways (Gergen & Thatchenkery, 1996; Ludema et al., 1997; Parsons, 1975). For example, Trudy Rudge and Kristi Morse (2001) demonstrated how orthodox discourses constructed schizophrenia and recovery in ways that silenced the subjective and embodied experience of patients and reinforced the inequity of their relationships with professionals (Waitzkin, 1989).

In contrast, academic psychiatrists Pat Bracken and Phil Thomas (1998) have suggested that "madness" may be an authentic response to intolerable stress; part of a human experience constantly haunted by contradiction and material conditions that are unresolvable. They have argued that, for many people, such circumstances have alienated them from their social environment

and a sense of self. Other commentators, such as Michel Foucault (1973a) and psychologist Louis Sass (1994), have described madness as a kind of *hyper-awareness*; a confrontation with the social world that only “lives” through artistic expression and is visible through the art of van Gogh, Munch and others (Sass, 1994; Greenberg, 1968; O’Hagan, 2010; Leibrich 1997; Leibrich & Carson, 2012). This representational perspective has been echoed by many people with their own experiences of extreme psychological states (Leibrich, 1997; O’Hagan, 2010; Roper & Pearson, 1999). These perspectives have reinforced the recovery philosophy in endeavouring to disrupt traditional attitudes to madness by giving it meaning, full human status and a pathway to a better life (O’Hagan, 2009b).

However, scholars have maintained that the establishment of socially legitimate categories of identity creates the power to warrant voice (Bourdieu, 1990). Therefore, a lack of visibility and positive representation has had serious impacts on the subjectivity and construction of social identities for people with lived experience of serious psychological distress. The attribution of illness identities, such as “mental patient”, has significantly affected the experience of that illness and frequently produced shame, stigma and voicelessness (Anspach, 1979; Lapsley & Yee, 2004; Mental Health Commission, 1997; Jacob Read, 2003a; Sontag, 1977). As Rudge and Morse (2001) discovered, people who experienced “schizophrenia” strongly resisted the scientific and “sanitising” (p. 68) constructions of their experience and struggled to disrupt the linguistic boundaries in order to create social identities and niches not limited by the “technologies of scientific knowledge” (p.74).

Broader societal discourses and institutional frameworks have also produced vocabularies of identity that reinforce narratives about appropriate roles, behaviour and relationships; some of which enjoy stronger institutional and material support than others (Ashcraft & Mumby, 2004; Harter, Patterson, & Gerbensky-Kerber, 2010). Historically people with lived experience of serious psychological distress have found it extremely difficult to disrupt socially ascribed identities embedded in normalised social structures and processes of identification (Cheney, 1991). Therefore, reclaiming valued identities and

subject positions has been a key focus for activist movements such as Mad Pride (Dellar et al., 2000; Warner, 2004) alongside the construction and establishment of validating and more empowering discourses (Anspach, 1979; Ashcraft & Pacanowsky, 1996; Holmer-Nadesan, 1996; Trethewey, 1997; Ward, 2009). As discussed previously, the discursive struggles for new subject positions and the evolution of discourses of recovery have been evident in the changing identity claims and linguistic evolution of those who have been users of mental health services (Cresswell, 2009; Everett, 1994; Morrison 2006)

However, a person's official clinical history has typically recorded only the unilateral, biomedical *patient* identity and the authoritative psychiatric discourse has demarcated boundaries of the relationship between professional and patient (Adame, 2006; Cheney & Ashcraft, 2007; Morrison, 2006; Trethewey, 1997).

Power, participation and the patient-professional relationship

Perhaps no site has more clearly illuminated the relationships of power and voice in health systems than the context of the patient and professional relationship (Edson, 1999; Sontag, 1977; Waitzkin, 1991). Normalised and hegemonic patterns of communication have been characterised by top down information transfer, where medical professionals “talk *to* rather than *with* their patients” (M. Brunton, 2000, p. 65). Thus, the assumption of superior knowledge and benign authority on the part of medical professionals has also suppressed dialogues that might facilitate alternative understandings and created tensions between ordinary, lay citizens and health professionals (Jureidini, 2012; Waitzkin, 1991). It has also radically restricted the layperson's participation in decision making about their health and well-being and limited the role of the patient to one of willing compliance with technical expertise (Barker, 2003; Geist & Dreyer, 1993; Waitzkin, 1991; Zoller & Harter, 2010).

Critics have maintained that health professionals have not only adopted roles as knowledgeable experts but have been able to determine both the environment and the agenda for the encounter (Waitzkin, 1991). “Patients” have typically been constrained from telling their own stories in their own

language, have had their emotional concerns re-directed as questions about physical symptoms and have been positioned as incapable of competent participation due to an apparent lack of the requisite knowledge and “understanding” (Geist & Dreyer, 1993; Harter et al., 2010; Waitzkin, 1991). Consequently, members of the lay public have become increasingly uncertain about the value and validity of their own expertise and interpretations of their life experience (Adame, 2006; Deegan, 1988; Geist & Dreyer, 1993; Kinsella, 2004; Oliver, 1998). This has been particularly the case in mental health service settings where a discourse of dependency and reliance on others for the ordinary management of their lives has been perpetuated (Deegan, 1996; Oliver, 1998; S. Rose, 2000; Saleeby, 2001).

Emerging models of holistic and participatory healthcare, in contrast, have emphasised the importance of approaching people’s experiences through their own worldviews and providing them with an authentic voice in conversations about their health and well-being (Leibrich, 2000; Silverman & Bloor, 1990; Zoller & Dutta, 2008). From this perspective patients contribute vital knowledge to the medical encounter. They are considered expert about their self, their motivations, their experience and their wider social contexts; all are essential to diagnosis and negotiations about treatment response (M. Brunton, 2000). Academic psychiatrists Pat Bracken and Phil Thomas (1999) have asserted that the psychiatric role should be to provide a safe, validating and potentially transformative environment so that people can develop their own authentic account of their circumstances and determine what needs to be accepted and what must be changed (Duncan et al., 2004; Jureidini, 2012). They have called for “professionals to maintain a sense of wonder” (Bracken & Thomas, 1999, p. 11) in order to help people come to terms with the pain of their distress, rather than simply seeking to get rid of it.

For those invested in deconstructing the dominant discourses of mental illness, first person recovery narratives have become important source materials (Leibrich, 2000b; O'Hagan, 1991, 2010; Ridgeway, 2001). These accounts have not only challenged the pathologising and deficit based constructions of their

psychological states but have simultaneously revealed people's inherent strengths and resourcefulness (Banks et al., 2004; Carey, 2005; Coleman, Goodman, & Smith, 2003; Leibrich, 2000b). Personal stories have proved to be disruptive to constructions of chronicity and hopelessness (Bracken & Thomas, 2004; Harter et al., 2006; Ludema et al., 1997; McGinley, 2005; Turner, 2002).

The role of personal stories

Foucault (1980) claimed that just expressing marginalised voices confronted a great silence, and was in itself a form of resistance. Other commentators have suggested that when such disqualified voices are acknowledged, previously submerged issues of justice, power and abuse of privilege are exposed (Daniels et al., 1999; Foucault, 1980; Morrison, 2006; White & Epston, 1990). Sharing personal narratives, therefore, has been important for the creation of a collective illness experience (P. Brown, 2007), and the development of politicised identities such as "psychiatric survivor" and "consumer" have been better positioned to contest stereotypes and construct alternative, persuasive discourses (Adame, 2006; Deegan, 1998; Everett, 1994; Morrison, 2006; O'Hagan, 1997; Ridgway, 2001).

People with lived experience of serious psychological distress, like other marginalised and activist groups, have frequently drawn from their personal, embodied and biographical histories in order to explain their experiences in terms of their social, cultural and lay perceptions (Adame, 2006; H. Brown, 1992; Harter et al., 2010; Zoller, 2012). Likewise, critical scholars have argued that dominant voices and official stories have repressed alternative perspectives and created the impression that one voice speaks for all others (Boje & Dennehy, 1993; Weick, A., 2000). They have argued that personal accounts of individual lives contradict, and have sometimes served to overturn, the grand narratives (Boje, 2001; Foucault, 1980; Harter et al., 2010; Morrison, 2006; Saleeby, 2001) and stereotypical accounts that have stigmatised and marginalised some groups (Mental Health Commission, 1998; Saleeby, 2001; White & Epston, 1990).

Personal narratives of recovery have been concerned to reframe the discourse to *living with* as opposed to *suffering from* the symptoms of extreme experiences (Banks et al., 2004; *Central Potential*, 2008; Copeland, 1997; Deegan, 1988, 1996; MHAC, 2008). Ridgway (2001), among others, has argued that recovery has meant a shift in perspective from viewing oneself as primarily a person with a psychiatric disorder to reclaiming a renewed sense of self and a transformation from alienation to a sense of meaning and purpose. Personal accounts, therefore, have validated and encouraged a shift to engagement and active healing (Buckingham, 2001; Burnet 2005; Deegan, 2001; Repper & Perkins 2003) rather than mere passive adjustment to chronic and inevitable circumstance (Copeland, 1997; Fisher, 2000; Repper & Perkins, 2003; Ridgway, 2001). These new authors have argued, without romanticising or denying the challenges, that it has been crucial to learn how to navigate the psychotic landscape and understand what has happened to them (Chadwick, 2002; Gould, DeSouza, & Rebeiro-Gruhl, 2005; Martyn, 2002; Mosher & Vallone, 1995; O'Hagan, 2010).

The on-going discursive tensions around recovery have made it difficult to describe an *authentic* recovery discourse. Scholars and other stakeholders, in recognising the historical marginalisation and powerlessness of stigmatised groups, have advocated for a privileged voice for people who have had extreme experiences of psychological distress (Adame, 2006; Banks et al., 2004; Deegan, 1988; Foucault, 1973a, 1973b; O'Hagan, 2004; Jacob Read, 2003).

The many voices of recovery

As discussed previously, recovery discourses have been indicative of the paradigmatic stance and interests of particular discourse communities (Bonney & Stickley 2008; Lapsley & Nikora, 2002; Ramon et al., 2007). Patricia Ridgway (2001) has stated that “until recently, the fact that people who experience prolonged psychiatric disability can grow beyond the limits of their condition and reclaim full lives was rarely mentioned in professional literature, perhaps because the idea of recovery is heretical within the dominant biomedical model” (p. 335). The Bonney and Stickley (2008) study, a thematic analysis of over 170

recovery texts in the UK, found that stakeholders conceptualised and constructed recovery and recovery orientated service delivery very differently.

Bonney & Stickley (2008) showed that people with lived experience of psychological distress described a far more subjective, contextualised and process-oriented view of recovery than mental healthcare providers who generally centred on symptom reduction and social functionality (Adame, 2006; Bradstreet & Connor, 2005; S. Rose, 2000; Slade, 2009; Sowers, 2005). This reinforced assertions from other commentators that people with lived experience of psychological distress, in speaking of their recovery, generally resisted an illness identity and were not typically concerned with being “cured” by medical intervention (Adame, 2006; Bradstreet & Connor, 2005; Carey, 2005; Fisher, 2000; Lapsley & Nikora, 2002; Mancini et al., 2005; Ridgway, 2001). They were also less interested in debating *causes* or being *maintained* and resisted suggestions of chronicity and hopelessness (Bracken & Thomas, 2004; Ludema et al., 1997; McGinley, 2005; Turner, 2002).

Service user authors described recovery as moving away from a negative mental health system of diagnosis and treatment to reclaiming an ordinary life, which may or may not include the abatement of symptoms (Bradstreet & Connor, 2005; Coleman, 1999; Martyn 2002; Mayers, 2000; Platz, 2006; Roberts & Wolfson, 2004). Their accounts challenged the orthodoxy of treatment responses, the expansion of classes of mental disorders (Duncan et al., 2004; Jureidini, 2012; Morrison, 2006), the proliferation of powerful psychoactive medications (Double, 2001, 2006) and the discursive closure around iatrogenic harm (Leibrich, 1997; O’Hagan, 1994; Pilgrim, 2005; Jacob Read, 2003b). They produced narratives and explanatory models of psychological distress that addressed more fully the complexity of a person’s experience and constructed it as intrinsically valuable and meaningful (Bracken & Thomas, 1999, 2005; Jureidini, 2012; Leibrich, 2000; John Read, et al., 2004).

Although these accounts were deeply personal, they also demonstrated a repertoire of common themes such as fear, pain and loss that has better enabled a wider, lay audience to understand and empathise with the deeply human bases

of these experiences (Banks et al., 2004; Jureidini, 2012; Leibrich, 2000b). There was also consensus among these authors about primarily social outcomes for recovery that were consistent with those sought by most people: safe homes, good health, adequate resources and meaningful roles and relationships (Banks et al., 2004; Bradstreet & Connor, 2005; Bonney & Stickley, 2008; Lapsley & Nikora, 2002; MHAC, 2008; Torrey et al., 2005).

All these commentators were more concerned with external and environmental barriers to good mental health and recovery, than internal and personal deficits (O'Hagan, 2002; Onken et al., 2002; Turner-Crowson & Wallcraft, 2002). Stigma, discrimination (Carling, 1995; Mental Health Commission, 1997, 1998; Ministry of Health, 2003; Sayce, 2000; Vaughan & Hansen, 2004), trauma (Rosenberg & Mueser, 2002), homelessness (Koegel et al., 1996; Schneider, 2010; Susser et al., 1990) and poverty (Leibrich, 2000; Polak & Warner, 1996; Schneider et al., 2004; Schneider, 2010) were all cited as evidence of situational factors that impacted on mental health and well-being both before and after serious episodes of psychological distress (Bonney & Stickley, 2008; Chamberlin, 1988; Leibrich, 1998).

Likewise, service user authored literature was far more likely to refer to societal or *community* recovery in terms of the enhancement of civil and human rights, social justice and equity (Everett, 1994; Cresswell, 2009; Morrison, 2006; Pearson, 2004). They invariably described recovery as a transformative process in which people have needed to recognise themselves as active agents in their own lives; people who possessed skills, strengths and resources despite being embedded within contexts that have variously supported or hindered their capacity for well-being (Rapp, 1998; Saleeby, 2001, 2002; Slade, 2009; Weick, Rapp, Sullivan, & Kisthardt, 1989).

Policy makers in the Bonnie and Stickley (2008) study tended to echo the themes and priorities expressed by service users about what worked in recovery, such as personal power, real choices and increased influence on service development. Notably however, in these texts, themes were couched in more general, ambivalent and ambiguous terms that were nevertheless revealing. For

example, some referred to services being *not just* clinical (p. 47) as opposed to the more confronting *service user led*. Similarly, they agreed that service users should be pivotal in the planning and delivery of flexible, personalised and responsive services rather than a system organised around professional priorities (S. Rose, 2000) but were far less clear how this could be achieved in terms of outcomes and a redistribution of power and resources.

Bonney and Stickley (2008) highlighted important contrasts between service user discussions of recovery and those of mental health professionals or healthcare providers. Service user accounts of recovery generally downplayed the role of professionals. Many believed that health care practitioners should be engaged by invitation only (Martyn, 2002; Repper & Perkins, 2003; Turner & Frak, 2001) and that hospitalisation was unhelpful and unnecessary (Coleman et al., 2003; Mosher & Vallone, 1995; Mosher & Boyle, 2004; Peters, 2009; Warriner, 2001). They were also very concerned with issues of compulsion and coercion in treatment responses and the corresponding loss of control over their lives (Kisely et al., 2005; Minkowitz, 2006; O'Brien & Golding, 2003; Jacob Read, 2003b). These authors emphasised the critical importance of staff attitudes and behaviours at times of crisis where choice and control were often arbitrarily removed (Campbell, 2001; Coleman, 1999; Fisher, 2000; Martyn, 2002; May, 2001; Repper & Perkins, 2003).

Professionals and providers, on the other hand, reified mental "illness" and were far more likely to frame psychological distress as a chronic lifelong condition that required "stabilisation", and therefore concluded that discussions of recovery could be viewed as promoting false hopes (Roberts & Wolfson, 2004). Similarly, some providers referred to the *integration of illness into the self* rather than the more empowering notion of self-acceptance (Ahern & Fisher, 2001; Chalmers, 2001; Kendell, 2000; Travis, Peters, Kerwin & Institute of Psychiatry, 2001; Turner, 2002). Such perspectives conveyed the sense of hopelessness and perpetuated the notion of a life sentence that was so vigorously resisted by service users (Barker, 2003; Gould et al., 2005; Kelly & Gamble, 2005; MacKay, 2005; Turner, 2002). Significantly, the acknowledgement

of iatrogenic harm was also poorly represented in the clinical or provider responses (Bonney & Stickley, 2008).

Professionals and health care providers in the Bonney and Stickley (2008) study tended to dilute the voices and centrality of service users' concepts of recovery. They used euphemistic, one-word generalisations and generalities that were difficult to associate with observable actions, behaviour and organisational practices. For instance, here as elsewhere, professionals and providers referred to "incorporating choice" rather than the more full-bodied call for "self-determination" and "service user leadership" that was characteristic of people with lived experience of serious psychological distress (*Central Potential*, 2008; Mental Health Commission, 2011; O'Hagan, 2009c; Pilgrim & Rogers, 2005, 2009; Warriner, 2009). Some professionals used the terms recovery and rehabilitation interchangeably, although no service users used this term, and these emphasised interventions intended to restore "normal" personal and social functioning as well as the development of "coping" skills (British Psychological Society, 2000; Holloway, 2002; Romme & Escher, 2000; Travis et al., 2001).

Here, as elsewhere, representations of a pathway to recovery were framed in terms of accurate diagnosis leading to "effective treatment" (Frese et al., 2001; Harrison et al., 2001; Rudge & Morse, 2001 citing McAllister & Chatterton, 1996). Unsurprisingly then, texts authored by professionals and providers promoted compliance, motivation and adherence to medication regimes as essential aspects of recovery (Bonney & Stickley, 2008; Travis et al., 2001). This stance inevitably reinforced the power relationships between professionals and service users where unsuccessful outcomes were routinely described as "failure to respond adequately" to medication (Travis et al., 2001). These stakeholders also anticipated closer links to medicine and biology in future (Kendall, 2000).

Texts authored by policy makers also identified the language of chronicity and hopelessness, stigma and low expectations as barriers to recovery, and acknowledged that these were as much features of mental health services as aspects of wider community attitudes (S. Rose, 2000; Sayce, 2000; World Health

Organisation, 2005). However, their continued reference to the importance of functional maintenance echoed the perspectives of professionals and service providers (Department of Health, 1999) and perpetuated claims of the superior efficacy of medication as treatment (Bonnie & Stickley, 2008; Moncrieff, 2008; Travis et al., 2001).

Stakeholder distinctions in discursive constructions of “risk” and “safety” were also apparent (Bonney & Stickley, 2008; Robertson, 2001). Some policy makers acknowledged that an overemphasis on safety, whether of service users or the wider community, were barriers to recovery and resulted in greater stigma (Fakhoury & Priebe, 2002, 2007; Gould, 2005; Turner, 2002). They supported service user authors in endeavouring to destigmatise and reframe risk as adventure and a catalyst for change (Keyes, 2002, 2007; Mayers, 2000; Leibrich, 2000a; Ware et al., 2008; Young, 2006). However, other policy makers defended mental health service providers in their requirement to anticipate and prevent crisis as well as reduce risk (Bonney & Stickley, 2008).

Many authors in the study expressed concern that people with lived experience of psychological distress were not seen to be leading the discourse on recovery (Bonney & Stickley, 2008; O'Hagan, 2009c; Pearson 2001) despite this being mental health policy in Aotearoa\New Zealand (Mental Health Commission, 1998; Ministry of Health, 2005, 2006). Bonney and Stickley (2008) concluded that while the personal perspectives of service users were “highlighted within policy rhetoric” they appeared to become “diluted as the practicalities of service provision are meted out” (p. 149).

In addition to the differing perspectives and discourses of these stakeholders, ambiguities also appeared to allow the co-existence of multiple interpretations or *translations* (p. 139) of key concepts, and these impacted significantly on the everyday practices of recovery in mental health services (O'Hagan, 2009a, 2010; Wallcraft, 2009). These disparities have pointed to the vulnerability of a recovery discourse to translation by wider and more powerful discourses such as biomedicine and managerialism. All of which contributed to the perception, especially among those with personal experience of

psychological distress, that “recovery is slipping from view” (O’Hagan, 2010) and has been fatally compromised, even colonised, before it has had a chance to flourish (Barker, 2003; O’Hagan, 2009a; Ridgway, 2001; Wallcraft, 2009).

Battles at the boundaries: Translations and the transfer of ideas

Organisational studies and communication scholars have long been intrigued by what happens at the boundaries of discourse communities, where different discourses intersect, interact and across which ideas are transferred. Conventional institutional and management theory has generally assumed organisational communication to be the “linear transmission of information along relatively stable organisational channels” (Mumby & Stohl, 1996, p. 62). This has led to unproblematic acceptance of a diffusion model for the transfer of ideas; one that assumes the simple transmission of concepts across discourse boundaries that is neutral in its effects (Creed et al., 2002; Zilber, 2001, 2006). However, recently it has become apparent that there are significant limitations with this model and discursive concepts and meanings do not transmit intact across discursive boundaries (A. Brown, 2000, 2004; Ganesh, 2010; Venuti, 1992, 2004; Zilber, 2006). In the *Problematic of organising* (pp. 139-140), I discussed how translation has been identified as a discursive strategy of institutional defensive work, whereby institutional arrangements of power and legitimacy withstand perceived threats. In the next section, I examine some of the communication processes, including translation, which occur when ideas are transferred across discursive boundaries. I pay particular attention to how concepts such as recovery have been negotiated and used by different “voices” and the effects these have on the discourse and practices within mental health services. .

As mentioned earlier (p. 139), scholars have opined that, typically, there is no genuine correspondence at the boundaries between discourse communities, and therefore no shared language that might adequately and faithfully translate concepts from one discourse to another (Chavez, 2009; Cheney, 2000; Ganesh, 2010). Translation theorists have maintained that people and their social communities interpret and adapt ideas, fashioning them into

legitimizing accounts in local, situated settings (Boxenbaum, 2005, 2006; Chavez, 2009; Cronin, 2005; Cooren, 2001; Ganesh, 2010; Zilber, 2002, 2006). Venuti (1992, 2004) and S. Brown (2002) have argued further that translations always favour the privileged interests and legitimacy of the translating culture thereby ensuring the maintenance of power relationships and the authority of dominant groups. In other words, translated accounts perpetuate socially legitimised systems, which have further justified the participation or exclusion of certain groups from the discourse (A. Brown, 2000; Cheney, 2000).

As Ganesh (2010) points out, translation dissolves notions of authenticity. The language of ideas is unable to move entire from one discursive location to another; something is always *lost in translation* (Cronin, 2005). Whenever meanings are absorbed into a new discourse, they have inevitably been transformed, and “in the act of transforming a breaking of fidelity towards the original is necessarily involved” (S. Brown, 2002, p. 7). This has meant that the transference of ideas across organisational boundaries, and throughout organisational fields, is necessarily a series of “negotiated” and evolving interactions (Ganesh, 2010) that shift the discourses through which people and groups make sense of their world.

This has meant that no matter how persuasive less powerful interest groups are, nor how concerned they are to manage the meanings of concepts and practices, they can never control how others will translate their concepts, problematisations or discourses in subsequent texts (A. Brown, 2000, 2004; Maguire & Hardy, 2009; Prichard, 2005; Reay & Hinings, 2005; Venuti, 2004). For example, scholars have noted how psychiatrists and other mental health professionals have appropriated and translated the discursive resources of recovery in ways that have cemented their position as authoritative (Craddock et al., 2008; Pilgrim & Rogers, 1999; Reay & Hinings, 2005; Wallcraft, 2009).

David Pilgrim (2008) noted that there are three particular translations of recovery evident in academic scholarship. First he observed recovery translated as the successful treatment of mental disorders and second, as the successful rehabilitation of those impaired by mental disorders. Third, recovery was

translated as the successful survival of social invalidation (Pilgrim, 2008; Pilgrim & Rogers, 2009). Each of these translations framed mental health problems in ways that privilege particular discourse communities. The first represents, and has maintained, the position of biomedical psychiatry and the status quo (Craddock et al., 2008) while the second accommodates the bio-psychosocial and “rehabilitation” perspective (Barker 2002; Ranz & Mancini 2008; Stromwall & Hurdle, 2003). Both of these translations of recovery have continued to emphasise the necessity and technical achievements of professionals. The third, and contrasting version, expressed a social and existential state of recovery; one achieved by people themselves from *within*, rather than *from*, their experience (Pilgrim, 2008; O’Hagan, 2010; Read et al., 2004). However, the differences in legitimacy and authority among these groups has meant that the less powerful have not been able to control how others have utilised or manipulated their worldview through language.

Margaret Brunton (2000) has commented that such translations are particularly significant in health and mental health environments where they have produced silo effects with professionals naturally aligning with colleagues who participate in the same speech community (Fairclough, 1992, 1995; Hazelton, 1997; Nairn, 1999; O’Reilly & Reed, 2011; Scott, 2008). These institutionally powerful groups have built common vocabularies, concepts and terms of reference that have led to ways of speaking that have privileged some members and excluded others in ways that are rarely equitable. For example, medical sociologists Pilgrim and Rogers (2005) were highly critical of an anti-stigma campaign commissioned by the Royal College of Psychiatry in Britain (1998) that used words such as “de-mythologise” to reinforce the belief that psychiatrists already, and solely, possessed the expertise to educate and enlighten general society. They concluded that the meta-objective of this study, ostensibly that “people suffering from mental disorders will be enabled optimally to contribute towards their own recovery” was purely an expression of “therapeutic paternalism” (p. 2548). Other scholars have argued further that recovery, despite having broad policy consensus internationally, has been

constrained by competing imperatives such as “risk minimisation” that shape everyday organisational communication and decision making (Anthony 1993; Pilgrim & Rogers, 2009; N. Rose, 1996, 1998).

Similarly, ambiguity has also been employed to allow communication between different discourse communities, where the imprecision of the discursive boundaries has provided a reassuring sense of common ground (Davenport & Leitch, 2005). However, Ganesh (2010), Alvesson and Karreman (2000), and others, have noted that reproducing particular vocabularies does not in itself constitute a subject position, and that drawing on multiple discourses, with the resultant ambiguity, is the communicative norm rather than the exception. Provisional use of language and “the ability to manipulate a whole variety of symbols without being tied to or identifying with any of them” (Jackall, 1988, p. 137) has illuminated the ways that individuals or groups with high status, in an institutionally powerful community, are active agents in the maintenance and reproduction of the discourses that sustain them. Alvesson and Karreman (2000) have referred to these acts as “telling the right kinds of stories to the right audiences at the right moment” (p. 1132).

Conclusion

This literature review has sought to unpack the important socio-cultural dimensions and contextual domains that influence the introduction and establishment of alternative meaning systems into conventional, and powerful, paradigmatic environments. Several areas appear to be under-researched; some, which are pertinent to this project, have informed my research questions. First, most institutional scholarship has focussed on the ways that institutions are maintained and reproduced as socially legitimate. However, little research has been undertaken to investigate how institutional discourses and organisational practices might be disrupted or destabilised so that alternative discourses and explanatory models might be established. Second, and relatedly, little scholarly attention has been paid to ways in which institutions undertake defensive institutional work, and the mechanisms and strategies by which they respond to challenge and threat. One such mechanism, which is significant for this project,

is translation, and the effect this has on emerging discourses and their discourse communities.

Critical and postmodern scholarship has encouraged challenges of the orthodoxy of dominant, taken-for-granted assumptions about the organisation of healthcare and, in particular, the positivist methodologies and scientific discourses that have underpinned Western mental health systems. Most of this scholarship, in the mental health field, has originated outside the professional bio-medical disciplines, from a range of related fields such as medical sociology, health communication and health promotion, psychology and social work. There has also been an increasing number of narrative accounts written by people with experiences of serious psychological distress. Together these bodies of literature have identified and investigated sites of struggles for the control of the meanings of socially constructed phenomena such as mental health and illness and underlined the need for social and organisational transformation.

The framework of problematics for critical organisational communication (Mumby & Stohl, 1996, 2007) has enabled a critique of the variety of issues underpinning the relationships and tensions among established and emerging discourses. It has also allowed me to draw together disparate threads from among a wide range of literature and structure an examination of theoretically pertinent constructs. It has been particularly useful for identifying the communicative practices, organisational structures and sites of social legitimacy that establish and preserve orthodoxy, while also identifying alternative spaces for action and the opportunities for transformation and social change.

In my analysis of the first problematic of rationality, I examined a range of literature that seriously questioned the rationality, and production, of scientific knowledge as unequivocal “fact”. These scholars argued that this socio-cultural legitimacy of western science has not only embedded techno-scientific reasoning within organisational systems and structures, but has meant that alternative forms of knowledge and meaning have consequently appeared *irrational* (Alvesson & Deetz, 2000; Fisher, 1990; Mumby 1988). Little scholarly attention, or research funding, has been directed towards exploring alternative rationalities

or conceptualisations of psychological distress because they have lacked social legitimacy.

Considering the second problematic, that of the relationships between organisations and the state, critical scholars maintain that individual, organisational and social transformations are inextricably linked to the emancipation of marginalised groups. These groups have struggled to resist the claims of others to know what is best for them and society, and have been collectively associated with the *empowerment agenda* (Rappaport, 1990). The emergence of alternative systems of meaning has enabled a critical shift in social consciousness for such groups. It has also created different expectations of how organisational visions, values and goals might be enacted.

Critics have noted that, despite the appearances of change and reform, the hegemonies created by the arrangements of power among dominant groups have serious implications for vulnerable groups. In the mental health sector, this has meant that the ideological and institutional authority of biomedicine and managerialism has concealed and naturalised multiple contradictions and inequities. Importantly, it has led to the sublimation of questions about the role of “community”, in community care, and developed of responsibility for the care of vulnerable people to professionals and services. These circumstances have proved remarkably resistant to challenge and disruption.

The third problematic, of organising, highlighted the relationships among clinical services and community NGOs in the mental health sector. Despite the community organisations endeavouring to facilitate peoples’ recovery by engaging them with their community in meaningful ways, they have struggled to establish credibility and legitimacy. In contrast, many of the principles, identified as fundamental to recovery, have been intensely challenging for traditional mental health services.

Organisations are influenced by multiple, interacting factors within, and beyond, organisational boundaries that enable or constrain the possibilities for organisational and institutional change. Unfortunately, most scholarship has been concerned with the ways that institutions persist, rather than how they can

be challenged, disrupted and ultimately deinstitutionalised (Reay & Hinings, 2005). Even less scholarly attention has been paid to the ways in which institutions act in order to protect their power and legitimacy through defensive institutional work.

Two distinct forms of institutional change efforts were identified in the literature (Maguire & Hardy, 2009). *Insider* change has often provided the appearance of change, through the adoption of the language of change, but systems of power and institutional authority have remained embedded. Insider change efforts, therefore, have typically been described as *restructuring*, or service improvement, rather than *reconstruction* or organisational transformation.

In contrast, *outsider* change endeavours are initiated by less powerful groups who are disadvantaged by the status quo. These groups, therefore, are more invested in systemic change, have nothing to lose and everything to gain by organisational and institutional transformation. This is certainly the case for people with lived experience of psychological distress, and to a lesser extent the community non-government organisations.

The fourth and final problematic was concerned with the issues of voice, particularly perspectives outside those of dominant groups. Critical and postmodern researchers have investigated how these groups are represented, and how they negotiate and construct alternative systems of organisational discourse and practice. However, the literature showed that, despite the emergence of personal narrative and explanatory models of people with lived experience of serious psychological distress, the *objective* expertise of medical professionals was still privileged over the *subjectivity* of human experience.

The literature demonstrated that issues of voice, in terms of organisational change, have been less about language and more about the power to maintain control over meaning systems. Multiple discourses and vocabularies exist within any organisational, or institutional, environment, some of which work in conjunction and others become sites of tension and resistance. In addition, new discourses and conceptual models disseminate throughout

organisational fields in ways that never faithfully reproduce their original meanings. In fact, several scholars have argued that discourses are inevitably *translated* as they cross organisational boundaries. Therefore, discursive shifts have not, necessarily, implied changes in the arrangements of power or the redistribution of resources.

The literature reviewed supported my inquiry interests, first, in understanding how an emergent discourse such as recovery might be constructed and enacted. In particular, it suggested how discourses might be “translated” by various voices and subject positions. Second, it identified potential sites of institutional disruption and possible processes for the establishment of alternative organisational discourses. In addition, it is indicated the ways in which institutions engage in defensive institutional work to protect their status and authority. This area of institutional work is, also, currently under-researched.

In the chapter that follows, I describe the research design and methodology of this project. In particular, I outline my methodological stance and connect this to my theoretical preoccupations and literature. I describe the recruitment and selection methods for my participant groups and finally I examine how I organised and analysed the data with respect to my research questions.

Chapter 5: Research design and methodology

Introduction

Underpinning this research project is the notion that, despite their best intentions, community NGOs, and mental health services generally, are not as effective as they would like to be in terms of becoming recovery-oriented (Barber, 2005; Jacobson & Curtis, 2000; Lord et al., 1998; O'Hagan, 1999, 2009; Sowers, 2005). Previous research showed that some aspects were working really well (Barber, 2005) and that, if these were clearly identified and articulated, they could possibly be enhanced in organisational practices and successes replicated. Therefore, I developed my research questions to enable a thorough examination of what was happening in these organisations:

1. In what ways are discourses of recovery constructed, negotiated and resisted in everyday practice within non-government community mental health organisations in Aotearoa\New Zealand?
2. How are institutional dynamics working to construct, constrain or contradict organisational practices in terms of becoming recovery-oriented?
3. In what ways are institutional dynamics being problematised and challenged within these organisations and to what effect?

In this chapter, I first discuss the methodological stance of my research, and how this is anchored in Critical Appreciative Inquiry methodology (Boje, 2010; Grant & Humphries, 2006; van der Haar & Hosking, 2004). Second, I explain how this methodological choice supports the research objectives and generated the kind of rich data required to answer my research questions (Denzin & Lincoln, 2003). I then describe the conceptualisation and enactment of the research design, including the development of research methods and tools, participant selection and recruitment and my responses to some issues that arose. This included some unanticipated but necessary revisions of some original assumptions of my research design. Finally, I describe the data analysis strategy and nature of thematic analysis I employed to represent faithfully the

participants voices while interpreting, meaningfully, the major themes and constructions that arose from the focus group, interview and textual data.

Methodological stance

Julian Rappaport (1990) has argued that “all research distorts, but some methods do so more than others: Different distortions give us different data, and they also empower different actors” (p. 57). Scholars within the social services field have similarly maintained that research should be collaborative; giving voice to the people and communities of concern and seeking descriptive authenticity (Dick, 2009; Lewin, 1946; Minkler, 2000; Stringer, 1996). Therefore, in this project, I was concerned to address the questions of not only “who does the content of this research empower?” but also “who does the method of this research empower?” (Rappaport, 1990, p. 58) and to provide space for workers in the community mental health NGOs to tell their stories of recovery in ways that enabled them to feel empowered and grow their practice (Barber, 2005; Stringer, 1996; Townsend, 1998; Wadsworth, 1998). So saying, I was also intent on ensuring rigour through the criteria of trustworthiness and fidelity to participants (Denzin & Lincoln, 2003; Dick, 2009; Lincoln & Guba, 1986) while remaining academically credible to a wider audience and producing results of significance that would be transferable to other organisational groups, communities and populations (Denzin & Lincoln, 2003; Dick, 2009).

Action research, therefore, was preferred ahead of other qualitative methodologies because of its emphasis on collaboration, empowerment and action for social change. Specifically, I believed that a particular form of action research, Critical Appreciative inquiry (CAI), would lead to deeper insights into the narratives and discourses that members of these NGOs were utilising in order to organise themselves as recovery-oriented within the context of Aotearoa\New Zealand mental health services (Boje, 2010; Fitzgerald, Oliver, & Hoxsey, 2010; Grant & Humphries, 2006; van der Haar & Hosking, 2004).

I was concerned to discover how recovery was being constructed by different people, groups and organisations as well as discerning what values and

larger discourses were at work (Alvesson & Kärreman, 2000; Cheney, 2002; Deetz & Mumby, 1990; Fairclough, 1992, 1993), and in what ways these were competing and to what effect (Maguire & Hardy, 2009; Mumby, 1997; Ramon et al., 2007).

My methodological stance was underpinned by two major assumptions: (i) a general, scholarly disenchantment in the social sciences with the grand narratives of science, religion and politics and their claims of universal truths (Foucault, 1972; Gergen & Thatchenkery, 1996; Harter et al., 2010; Rappaport, 1995, 2002; Taylor, 2004); (ii) that organisations are discursive constructions of communicative practices, situated within historical, cultural, social, economic and political contexts (Fairhurst & Putnam, 2004; Grant & Humphries, 2006; Leclercq-Vandelannoitte, 2011). The section that follows examines the critical and postmodern epistemological bases for my methodology.

The critical and postmodern traditions as methodology

Bryan Taylor (2004) noted that the postmodern turn in organisational research has opened traditional methods to critical scrutiny, taking nothing for granted and questioning the nature of the research process itself. Following Foucault, he argued that “all inquiries after truth” (p. 135) are suspect and have served to mask and/or serve particular interests in local, cultural and political struggles (Foucault, 1972, 1980; Weber, 1946). Scientific methods of knowledge generation, for example, have privileged professional accounts as more “truthful” than other organisational narratives and have routinely invalidated the voices of ordinary workers (Harter et al., 2010; Lapsley & Nikora, 2002). However, Foucault argued, professional authority is merely truth sanctioned by tradition and therefore scholars “should not leave a paradigm unchallenged simply because it is dominant” (Zuber-Skerritt & Farquhar, 2002, p. 103).

In response, postmodern organisational communication scholars have developed methodologies that expose and challenge the preferred and historically dominant stories; instead seeking out suppressed narratives and meaning systems (Adame, 2006; Broadfoot & Munshi, 2007a, 2007b; Coney,

2004; Pilgrim, 2005; Taylor, 2004; Weick, 2000). These scholars, have contended that the lived experience of everyday sense making within organisations and communities is characterised by many “overlapping, interweaving, and perhaps even competing, narratives rather than a single coherent and authoritative storyline” (Whittle & Mueller, 2010, p. 113). The critical gaze in this project, therefore, was intended to facilitate insight, for both the researcher and participants, into their degree of identification with, and participation in, privileged or alternative discourses.

Postmodern inquiry has sought to increase awareness of these struggles and expose the powerful and institutionalised discourses that have gained coherence, authority and legitimacy. In pragmatic terms, for many social service organisations, this has meant that their practices and decision-making have been governed by managerial and professional norms that have actively marginalised, even foreclosed, alternate voices and interpretations (Barber, 2005; Deetz, 2004; Holmer-Nadesan, 1996; Trethewey, 1997). The strengths, capabilities and resourcefulness of workers in these organisations have, therefore, been routinely excluded from forums that determine the strategic development of the sector (Barber, 2005; Holmer-Nadesan, 1996; Kukler et al., 1998; Wade, 1999; Warriner, 1997).

Julian Rappaport (1990) argued that a commitment to an empowerment social agenda in research means “identifying, facilitating or creating contexts in which heretofore silent and isolated people, those who are outsiders in various settings, organisations and communities, gain understanding, voice and influence over decisions that affect their lives” (p. 52). Critical and postmodern organisational communication scholars, therefore, have supported the development of methodologies that echo and support more participatory communication and emancipatory practices in organisations (Alvesson & Karreman, 2000; Rappaport, 1990; S. Rose, 2000; Spano, 2001). Specifically, a critically appreciative approach to this inquiry attended to previously unheard narratives of organisational life from the people for whom these matters were of immediate and personal concern (Ridgway, 2001). It did not warrant any

particular expertise or subject position (van der Harr & Hosking, 2004) but was intended to facilitate understanding and generate knowledge of direct relevance to participants, giving them ownership of the findings and a sense of ethical fairness in the knowledge generation process (Berg, 2003; Barber, 2005).

Critical methodologies have required scholars to take an ethical position with regard to the implications of communicative activities including research (Deetz, 2001; Rappaport, 1990, 2001). They have maintained that no scholarship is value free, and researchers should abandon a pretext of disinterested science and develop a critical attitude, or reflexive stance, that explicitly identifies and acknowledges their partiality (Horkheimer, 1972; Jermier 1998; Rappaport, 1990, 2001). As members of the critical tradition, action research methodologies, including CAI, have also resisted a naive enchantment with “objective methods (that have seemed) to strip human behaviour of its meaning, agency, purpose and social context” (Lapsley & Nikora, 2002, p. 5).

Despite surface disparities, both appreciative and critical methodological approaches assume that organisational change will be most successful when it has meaning for, and is to some extent owned by, those most affected by that change. In the section that follows I discuss the salient aspects of CAI that informed this project and its pursuit of enlightened social and organisational change (Dick, 1993, 2009; Stringer, 1996).

Action research and Critical Appreciative inquiry

Critical Appreciative inquiry (CAI) and other action research methodologies share an interest in the pursuit of enlightened social and organisational change. They enact research that seeks to empower and mobilise people, and resist attributing responsibility to them for the existence of problems, instead validating and trusting their expertise to develop solutions (Rappaport, 1990). All these methodologies have a commitment to working with democratic values and to authentically and faithfully represent voices that are often ignored (Minkler, 2000; Rapp et al., 1993; Rappaport, 1990; Reason, 1994,

2000). This has led to forms of action research becoming important methods of inquiry in the fields of health, education and organisational change management.

All action research methodologies invite participants to explore the significance of their experience and actions in a collaborative, discursive space that acknowledges and validates their expertise, differences and contributions (Barber, 2005). Like other forms of narrative inquiry, this methodology privileged participants' representations of experience as a source of insight (Clandinin & Rosiek, 2007; Harter et al., 2006). Participant groups could also, potentially, destabilise dominant stories by coming to recognise alternative possibilities and preferred outcomes that were frequently hidden by dominant accounts.

The epistemological basis of both critical and appreciative approaches to inquiry is illumination of the ways in which power is mediated through discourse in determining organisation realities (Alvesson & Deetz, 2000). Typically, organisational change initiatives have been imposed from the top down and drawn only on managerial interests and perspectives. Traditional problem and deficit-based analyses have created an exaggerated spotlight on perceived weaknesses within organisational communication and practices. Focusing solely on finding specific solutions to perceived problems has created discursive closures that have limited the ways in which issues are framed and possibilities envisaged.

Critical Appreciative inquiry differs from other action research methodologies in that it resists focusing on problem analysis in favour of identifying effective practice. Problem definition is relegated to a place from which to identify and encourage potential solutions that are already "known", at some level, to participants (Hall & Hammond, 1998). Therefore, the intention is to generate visions of positive and preferred futures, as well as identifying a range of possible pathways and strategies towards those futures (Hammond & Royal, 1988).

The fundamental assumptions that underpin appreciative inquiries are, first, that in every situation or organisation something is already working.

Second, in any situation, there are multiple realities and possibilities for new action. Third, and importantly for this research, it is assumed that the very act of asking questions influences and shapes the reality for participants in some way (Cady & Caster, 2000; Cooperrider & Whitney, 2000; Zorn, Roper, Broadfoot, & Weaver, 2006).

At its simplest, CAI involves interested groups in a thorough exploration of what works effectively in their past and current situations, and simultaneously engages them in identifying potential pathways for change, anchored in what is already known and “sensible” (Reason, 2000; van der Haar & Hosking, 2004). The process, therefore, encourages movement away from, problem-laden narratives and invites more hopeful and aspirational articulations of preferred futures (Hall & Hammond, 1998). It provided participants with the opportunity to develop alternative views of organisational reality through a socially shared appreciation of organisational life, and to develop a “critical consciousness” of their individual and organisational circumstances and capacities within larger social contexts (Freire, 1973, 1996; Minkler & Cox, 1980; Zorn et al., 2006).

Combining appreciative and critical approaches expanded the sense of “appreciative” from any trivial sense of naïve “positivity” (Ehrenreich, 2009; Fineman, 2006a; Grant & Humphries, 2006). A more complex definition of appreciation as *coming to know*, and more deeply understand, increased the capacity of my methodology to engage with the complexities of organisational realities, as they were experienced by diverse organisational members (Cooks, 2000; Fitzgerald et al., 2010; Grant & Humphries, 2006; van der Haar & Hosking, 2004). This sense of appreciative was defined by Grant and Humphries (2006) as articulating and dialoguing the best of what *was*, what *could be* and what *should be*, while envisaging and innovating the pathways to what *might be*.

The methodological choice enabled participants to maintain their gaze on how they and their organisations could succeed rather than getting lost in endless discussions of why they fail (Barge & Oliver, 2003; Harter et al., 2006; McCashen, 2005). The appreciative gaze allowed them to seek out the “best of what we do around here”; the critical gaze widened the scope to examine how

they might *change* “the way we do things round here” (van der Haar & Hosking, 2004).

This did not mean ignoring the real issues that faced individuals and organisations but, rather, it represented a conscious choice to attend to the achievements, capacities and resourcefulness that had enabled successful outcomes previously and thereby identify the seeds of future possibilities (Saleeby, 2001).

It was anticipated that participation in this research process would encourage new understandings of organisational realities, and that alternative discourses would present themselves. While these new constructions of experience could not guarantee immediate action, they could still generate transformative power.

Reflexivity and my role as research coordinator

Reflexivity is implicit in all forms of action research (AR) and predicated on researcher participation in the world under study (Burawoy, 1998). Therefore, a crucial feature of the research design is how a researcher should treat her own voice (Denzin & Lincoln, 1998; Dick, 1993, 2009; Reason, 1994, 2000). All variations of AR emphasise engagement rather than detachment and Julian Rappaport (1990) has commented that “to say that collaboration is important is to say something about the relationship between the action-researcher and the persons of concern [and] when people genuinely collaborate, they engage in a mutual-influence process” (p. 54). This meant that as a research collaborator I was self-consciously engaging with the world of the participants interacting as an interested participant with a background of experiences in the sector and an explicit optimism about its future.

The overarching ambition of this project was to identify and champion the potential for organisational change, not support compliance or resignation with established authorities and dominant discourses. Under these circumstances, methodological sophistication was secondary to the generation of practical and popular accounts that could be used to envisage individual and

organisational transformation; whether or not these advanced theoretical considerations (Winter, 1989). Being reflexive, in this case, meant balancing the need to be inclusive of multiple, sometimes competing, narratives and the idiosyncrasies of local and messy realities without reducing the analysis to mere babble (Boje, 2001; Cunliffe & Coupland, 2012). In other words, as research coordinator I needed to make sense of the narratives that participants offered me, but in ways I could be sure faithfully represented their intent, and desires for change, without allowing my own synthesising role be shaped by my pre-existing proclivities.

My methodological and design choices were inevitably influenced by my own identifications and subjectivities, and these permeated the research process, including the questions I asked and in the ways in which I tried to answer them. My previous research, examining strengths-based practices and community support work, made me sympathetic, knowledgeable and committed to the future of the sector (Barber, 2005). I also had extensive experience in the sector, as a programme coordinator and service manager, at an exciting period of sector change: to wit, the establishment of Mental Health Commission, the publication of *The Blueprint* and the introduction of the recovery discourse into a community sector that was, for the first time, offered a level playing field to develop innovative responsive services. All this meant that, as a moderator and interviewer, I was self-consciously and transparently engaged with the issues for the sector and it was clear to participants that I was *on the side of* the NGOs.

My stance was an important aspect of my access to, and engagement with, prospective participants, but I needed to account for these interactive effects in the analysis (Stewart, Shamdasari, & Rook, 2007). Further, I needed to be aware of any special privileges I might accrue to myself by virtue of my engagement with the sector, academic background, and overall control of the shape of the project (Barber, 2005; Rappaport, 1990, 1995). My task then was how to represent faithfully the voices of the other participants, while remaining cognisant of my own engagement and control of methodological processes.

It is not possible to be both reflexive and omniscient. There will always be a level of distortion inherent in the philosophical “situatedness” of an observer, participant or research facilitator. However, being critically appreciative meant that I claimed no privileged position as the research facilitator. This meant careful, self-conscious and continuous examination of the processes for gathering, organising and interpreting the data as well. In particular, it meant identifying the norms and assumptions that guided my thinking and actions throughout the project and checking that the methods were relevant and appropriate to any subsequent knowledge claims. At the analysis stage of the research it meant clearly establishing a systematic logic for assessing and communicating the interactive process.

Coordinating the research meant being clear about what I wanted to hear about, to guide and focus the discussion; but, at the same time, I needed to keep the conversational space open for participants to be able to fully explore their own priorities, expressed in their own language. I relinquished any sense of the “god’s eye view” and established a mutually influential process that remained open to changes in the thinking and perspectives of all involved (Barber, 2005; Gergen & Gergen, 2006; Rappaport, 1990, 1995; Reason, 1994). Paradoxically, this stance gave me less control over where the discussions might lead, and restricted my opportunities as moderator to challenge some perspectives to see further below the surface. However, I also needed to remain alert for contradictions and the existence of continuously negotiated positions (Barber, 2005; Rappaport, 1995). Participant feedback forms indicated that I managed this balance.

There were limitations to my subjectivity, not least of which was my understated authority as researcher. I had previous knowledge and a background of scholarship in the subject area, prior knowledge and perceptions of some of these organisations from my background in the sector, as well as a sense of obligation and loyalty to my research participants. Therefore, my level of disclosure, or non-disclosure, about my own predilections created a possible ethical dilemma. This was compounded in two interviews where, in one I had my

own “interpretation” of what was being said, and in the other where I straight out did not believe the participant’s description of her organisation’s practice priorities. In the event, neither transcript proved significant to the major themes emerging; however I was left with the uncomfortable awareness that I had not considered a strategy for dealing with difficult situations in interviews; nor had I adequately considered the boundaries between representation and interpretation of participant talk.

So saying, the overall responsibility for the theoretical and design aspects of the project were mine; as were the deadlines and responsibilities for ensuring the project was completed. As the ultimate author of the work it was also my responsibility to ensure the research maintained a level of academic rigour and was a conscientious endeavour to “tell the truth”. I was responsible for summarising what was learned and for ensuring that it was both a faithful representation of participants’ perspectives and a careful analysis and interpretation of significant issues and themes that emerged (Denzin & Lincoln, 2003; Dick, 2009; Tuckett, 2005). Therefore, I needed to maintain a certain amount of control over the conditions affecting the research and I was inevitably the ultimate arbiter of inclusion, emphasis, and integration (Parker & Tritter, 2006; Stewart et al., 2007; Woodring, Foley, & Rada, 2006).

Research design and methods

I required a research design that would honour the expertise and knowledge of participants; but which also enriched and expanded their current understanding of their situation. I was concerned that participants’ stories should be told in ways that would uncover how organisational decisions were made, which organisational stories were privileged, and how this affected individual and organisational discourses as well as service delivery. In this sense, my methodological choices followed Freire’s (1973) concept of critical consciousness in facilitating everyday members of organisational communities to develop new ways of seeing, thinking and talking about their organisational realities. This was intended to lead to the creation of new meanings and changes

in the world of experience for participants, researcher and organisations (Hill & Capper, 1999).

Therefore, I intended to create an energetic open space in which participants could explore and develop their own constructions of how organisations might align themselves more effectively with their own core visions and values. I anticipated that, subsequently, this more evolved and communal awareness of organisational contexts could inform changes in how participants expressed themselves and increase their capacity to take action towards a desired future (Alvesson & Deetz, 2000; Zorn et al., 2006).

Requirements of the research design

As an inductive, naturalistic inquiry, I did not pre-determine too many aspects of the research design, but instead developed more flexible strategies to respond to emerging content and particular contextual realities. So saying, the credibility of the research design rested on how theory, methodology, research processes and research rationale combined to support the research objectives and provide a sensible way to develop and answer the research questions (Denzin & Lincoln, 2003; Punch, 1998). Previous research and literature suggested that implementing a recovery orientation in mental health services was proving difficult to achieve (Barber, 2005; O'Hagan, 2009; Turner-Crowson & Wallcraft, 2002). In addition, the role of the community organisations in the Aotearoa\New Zealand mental health sector seemed to be diminishing in some important ways (Harrison, 2010; Warriner, 2010).

Organisational development and action research scholars have noted that effective organisational change needs to be anchored in meaningful ways to people's collective experience (Dick, 1996; Reason, 1994). This indicated the importance of developing participatory research practices, driven as far as possible by "community" priorities, multiple voices and a shared understanding of the circumstances of these organisations and their constituting discourses (Deetz, 2003; Dick, 1996; Greenhalgh et al., 2005; Reason, 1994). I endeavoured to find ways to elicit the everyday theories and explanatory models that ordinary

people used within their organisational environments in order that we all might come to a better, shared understanding of what meaningful social action might look like in mental health services (Denzin & Lincoln, 1998, 2003; Harter et al., 2010).

Any research design is required to be a disciplined, systematic and analytically rigorous inquiry. Action research methodologies achieve rigour through evaluation of their “worthwhile”-ness to participants (Dick, 2003; Reason, 1994). Similarly, other qualitative scholars have argued that narrative “truth” is characterised by trustworthiness and authenticity rather than scientific objectivity (Guba & Lincoln, 1998; Kincheloe & McLaren, 1998; Lincoln, 1995). Some have gone further to claim that methodological rigour is a better measure of academic legitimacy than cognitive impenetrability (Dick, 2003; Greenhalgh et al., 2005). Therefore, there needed to be a logical coherence throughout all aspects of the project and it needed to express accurately the organisational realities of the multiple stakeholders (Conle, 2001; Lincoln, 1995).

Yvonna Lincoln (1995) described trustworthiness and authenticity as indicative of research that produces rich, thick, detailed descriptions and where the constructions of all participants are represented with equal power and vigour. Likewise, Mulholland and Wallace (2003) have argued that the “legitimation of the findings in qualitative research is enhanced by multiple tellings of stories of lived experience” (p. 22). In addition, the research needed to be conducted and reported in such a way that the arguments could be critically examined and the conclusions deemed credible (Guba & Lincoln, 1994). All of the above influenced my choices of methods and procedures for gathering appropriate data.

In the end, focus groups were a logical and useful choice for participants to engage in conversation and share their experiences in a relatively open forum. I also used semi-structured interviews with managers for purely practical, and geographical, reasons. In addition, texts such as national strategy and policy documents provided useful data and framed the interactive discussions within

the current context of the Aotearoa\New Zealand mental health sector (see Appendix 5 for list of texts).

Methods: Focus groups and semi-structured interviews

Focus groups have enjoyed resurgence in the fields of social and health science; largely due to their suitability for gathering the perspectives of people who have been previously unheard or overlooked in research (Kidd & Parshall, 2000; Koppelman & Bourjolly, 2001; Stewart et al., 2007; Woodring et al., 2006). They have also proved to be an excellent way of unearthing and examining public understandings and experiences of phenomena such as mental health and illness (Kitzinger, 1995). It was important for this research project that the choice of method provide a voice for people who have not previously been invited to the discussions that inform and their everyday organisational realities.

Fern (1982) concluded that focus groups are effective because, in contrast to interviews, they lower participants' caution and reserve due to their relative anonymity and reduction in accountability. He posited that a well-facilitated group creates an atmosphere of excitement and enthusiasm that encouraged participants to freely express their ideas and feelings. In addition, again unlike interviews, a variety of communication forms such as jokes, anecdotes, personal stories, and expostulations become available; all of which yield important clues as to participants' attitudes, values and priorities (Kitzinger, 1994). Fundamentally, and philosophically, focus groups were chosen as the preferred form of data collection because, as Lambert (2006) has explained:

In conversational storytelling, [. . .] stories lead to stories lead to stories. We can watch the patterns unfold as each story transforms the conversations, the meaning, and the exchange into deeper and more intimate communication. There is so much invisible power in this simple activity that people walk away from some gatherings feeling transformed . . . (p. 11).

The *focused* aspect of the groups signified that participants were people who shared a common interest in the mental health sector. Therefore, I

expected the participants to have a strong engagement with the subjects under discussion. In addition, the inherent flexibility of focus groups offered a responsiveness that would be lost in quantitative techniques (Morrison, 1998). They could also be conducted within more naturalistic and social settings, were cost effective in terms of time and resources and delivered a larger data yield (Krueger & Casey, 2000; Morgan, 1997; Parker & Tritter, 2006).

The open-ended nature of the focus groups offered participants choices about what they talked about, how they responded and encouraged interaction while also allowing them to change their minds while they were together (Zorn et al., 2006). The group context encouraged diversity and divergence, inviting deeper consideration of the issues under discussion. I anticipated that the process would allow ambiguities and contradictions to emerge, and that these would either be reflexively challenged and/or would expose implicit knowledge, beliefs, values and other taken-for-granted meanings among group members.

So saying, I was intent on examining not only people's constructions of recovery and what this meant for community mental health organisations, but how and why they came to think as they did and whether this changed over the course of a discussion. I was interested in the language they used, the concepts they drew on and the associations they made when making sense of important ideas. I believed that the interactive features of these discussions would be important indicators of the various frameworks they constructed in order to make sense of their organisational realities and their role within the mental health sector.

As indicated previously, the decision to use both focus groups and semi-structured interviews was pragmatic rather than philosophical (Lambert & Loiselle, 2008). With only one, or sometimes two, senior managers in an organisation it would have been difficult, as well as costly, to coordinate focus groups for these participants. However, postmodern trends in interviewing have blurred the boundaries between formal interviewing and more conversational methods (Denzin & Lincoln, 2003), and in both methods, I was intent to facilitate

collaborative conversations that created a space for participants to develop the ideas and issues that were important to them.

Different methods provide different data but also offer opportunities to illuminate different understandings and add richness to the analysis (Lambert & Loiselle, 2008). It was important to remain alert to any hierarchy of data that might develop in the analysis and to ensure all voices were treated fairly. In addition, and to provide as much comparability as possible, the interviews were loosely structured and guided by the same prompt questions as the focus groups.

Participants were organised into three cohorts according to their roles and responsibilities, within the typical management structures of these organisations. The criteria were a prospective participant's relative autonomy and power to influence decision making as well as their capacity to influence the strategic direction and development of their organisations. These criteria also, naturally, grouped people in terms of the nature of their relationships with service users and delivery of core services.

Participants were, therefore, separated into the following categories:

1. "Flax root" support workers. These have no authority over others, limited decision making power and primary relationship(s) with service users. There were 73 of these, predominantly female of whom, 26 also identified as people with lived experience of serious psychological distress. Of these, 20 were in designated peer support roles (see Tables 2 & 6, Appendix 1).
2. Service coordinators and Team Leaders. These have some supervisory authority over others, have some decision-making responsibility and participation in organisational processes, are accountable in both directions and have less direct contact with service users. There were 38 in this cohort, the vast majority of whom were female with five who identified as having lived experience of serious psychological distress.

Four had designated peer support lead roles (see Tables 3 & 7, Appendix 1).

3. CEOs and Senior Managers. These have relative autonomy and authority over others as well as a significant capacity to make decisions and control strategy, policy, planning and organisational development, and a limited direct contact with service users. There were 20 participants in this category, 16 of whom were interviewed and five who were involved in focus groups. Interestingly 60% of this influential group were male. Five identified as people with lived experience of serious psychological distress. Three were managers of service user led organisations (see Tables 4 and 8, Appendix 1).

As previously explained, I conducted semi-structured interviews with most senior managers. However, I was able to conduct a focus group with the whole senior management team from one large NGO in Wellington, who had kindly made themselves available. In addition, I was able to interview two members of the senior management team in three other organisations, two in Auckland and one in Hamilton.

In the next section, I describe how participants were selected and recruited, and how the data was collected.

Procedures for participant recruitment and data collection

The focus groups and semi-structured interviews provided a rich set of data from a total of 131 participants, representing 29 community mental health NGOs, concentrated in four major DHB regions: Auckland, Waikato, Wellington and Christchurch (see Tables 1-4, Appendix 1). Participants were identified and invited through a variety of mental health databases and network mailing lists. This provided a mix of organisational types, included urban and rural organisations, but was resource efficient in terms of travel and time.

Participants worked in a variety of community service settings including residential; home based support; employment and vocational support; consumer and family support. Participant organisations included four that are designated

service user organisations, three that provide support for families and two Kaupapa Māori organisations. In addition, two organisations have designated Peer Support teams and four have Kaupapa Māori arms to their services. Overall, there was a mix of residential and home-based community support organisations as well as advocacy and consulting services, drop-in centres, day programmes and peer respite services (for a full summary of organisational demographics, please see Tables 5 & 6, Appendix 1).

Participant selection and recruitment

The recruitment process was both purposive and opportunistic. I had my own networks within the community mental health sector; some of these were participants in my Master's research project. I was also able to recruit participants from mental health training workshops, for community practitioners throughout the country, that I had facilitated. I used the snowball effect of these encounters to follow leads and take advantage of unexpected opportunities to invite participants. I also had meetings with the national Service User Lead from Te Pou¹⁴, and was subsequently invited to present a seminar to the other members of the clinical service team in Hamilton. I followed this by meeting with the Te Pou national workforce development coordinator, who was leading the development of the national mental health service framework. All of these encounters created fresh contacts and opportunities to expand my networks in the sector, some of which resulted in active participation in the project while others offered food for thought and reflection.

I did not originally intend to directly recruit service users (or people with lived experience of psychological distress) as participants. This was partly due to the ethical issues and an unwieldy enlargement of scope. But it was also due to the philosophical stance that the views of these groups were already in the

¹⁴ Te Pou o Te Whakaaro Nui [legal identity Te Pou Ltd.] is the organisation with responsibility for the mental health sector workforce and service development in Aotearoa\New Zealand. It incorporates all of: Mental Health Research and Development Strategy (MHRDS), the Mental Health Standard Measures of Assessment and Recovery initiative, known as MH-SMART and the Mental Health Workforce Development Programme (MHWDP).

public domain through numerous texts. I considered that it was long overdue for others in the sector to make the organisational and sector changes for which service user groups had long advocated. Therefore, I intended to represent service user perspectives, through the growing body of consumer literature and research, as the context for the other participant views.

I did recognise, however, that service users would naturally become participants because many worked in the sector as support workers, peer support workers and leaders of service user organisations. Similarly, other participants, naturally, would be family members. However, as I began to analyse the data, it was immediately apparent that these participants' perspectives were fundamentally different from those of their colleagues, and needed to be identified separately within each cohort.

Question formulation

The formulation of the focus group question framework was crucial to unearthing personal and organisational strategies for successful practice (see Appendix 2 for focus group question guide). I wanted to invite personal stories, and follow these with questions that encouraged further exploration and reflection. The nature and structure of the question framework, and the systematic sequencing of questions, were carefully considered to allow familiarity with the topic to build but also to ensure there was adequate time for individuals to recollect and listen to others.

I was also important to develop questions that were explicitly *appreciative*. I did not intend to deny or minimise issues of serious concern to participants, but I did want to provide opportunities for them to articulate their enthusiasms and stories of successful outcomes. This was a conscious alternative to re-visiting problems and circumstances that were unlikely to be helpful for initiating organisational change (Barge & Oliver, 2003; van der Haar & Hosking, 2004). Finally I created questions that provided opportunities for participants to identify the issues in the sector that needed to be talked about, what other people in the community should know about these organisations and

the work they do as well as “*What is currently not on the agenda that should be?*”. The responses to these questions, and the post-focus group feedback forms, ensured that I was capturing data about the most relevant, significant and current issues facing these organisations.

In the next section, I provide the chronological outline of the actual procedures I undertook for data gathering and collation.

Data collection procedures

The first focus groups, convened in Hamilton, were intended to be pilot groups where participants would provide feedback about all aspects of the process. I anticipated adjusting aspects of the research design in response to the data gathered from these groups. I had developed pre-focus group forms (see Appendix 3) that captured demographic information as well as initial, benchmark data such as organisational Mission Statements, personal and organisational stances on recovery etc. From these I was able to get an initial, thumbnail impression of the preferred stories and current understandings of recovery in the sector; as well as the official, explicit organisational intentions and significant misalignments with the personal values of participants.

Similarly, I created post-focus group forms (see Appendix 4) that were intended test the appropriateness of my issue identification and the relevance of the question formulation. Both the *pre-* focus group forms (see Appendix 3) and *post-* focus group forms (see Appendix 4) were designed to inform the future roll out of the project. The collated summary of this data can be found in Appendix 6 and is discussed in the analysis section. Suffice to say that this material not only demonstrated that the project was on the right track but also proved to be rich data in itself. Therefore, I included these forms in all subsequent focus groups and interviews.

Establishing good practice for the focus groups

An intrinsic tension exists between the theory and pragmatics of forming focus groups, which are invariably situated within an environment that is largely constructed by the facilitator. Although, epistemologically, there is little

difference in data quality between focus group and any other data collection method, many factors impact on good practice in data collection and rigour in analysis; all of which required careful consideration (Freeman, 2006; Parker & Tritter, 2006).

First, the composition of the focus groups required careful thought. While there is no prescription about the size or context of focus groups, and no data is more authentic than any other, research suggests that the composition and structure of groups, their relative homogeneity or diversity and the nature of participants' relationships with each other need to be taken into account (Morgan, 1997; Morrison, 1998; Zorn et al., 2006). It is generally agreed that there is a tendency for greater conformity in heterogeneous, or mixed, groups as participants are more concerned about the inter-personal relationships. In contrast, some scholars argue that groups, which are more homogeneous in terms of demographics, personality and physical characteristics tend to work better (Kitzinger, 1995; Krueger, 2000; Morgan, 1998). Others warn that the extent to which the groups are constrained by pragmatic concerns and organisational issues are all factors that need consideration and planning (Stewart et al., 2007).

Therefore, as far as possible, I wanted to minimise the complications of asymmetrical power and status relationships; so I convened the focus groups with peers from the same, or other local, organisations. This aspect of the research design was intended to provide an environment where participants would feel free to express themselves in the ways that were most meaningful to them and limit the possibility that some members may be considered more authoritative within a group (Zoller & Fairhurst, 2007).

It is widely believed that facilitating encounters among people will generate data that goes beneath surface explanations; that is inherently richer than that gained through interviews. Therefore, the interactive effects and group dynamics were integral in encouraging the emergence and development of issues and ideas (Parker & Tritter, 2006). As moderator, I needed to carefully facilitate the development of the group dynamics, but gradually a kind of synergy

grew among participants, which was apparent once all had had the opportunity to contribute (Kitzinger, 1994, 1995; Stewart et al., 2007; Woodring et al., 2006). A primary role for moderating the groups was to elicit participation from each participant as early as possible, and I did this by inviting each person in turn to introduce themselves and describe their role. I explained that this was also important to get their voice on tape for the transcriber.

Criticisms, limitations and realities in the field

Focus groups produce primarily social and interactive meanings (Kitzinger, 1994; Zorn et al., 2006). As a researcher, I needed to accept that multiple constructions of meaning were possible based on different constructions from those engaged in the discussion (Berger & Luckmann, 1966; Tuckett, 2005). This meant that I needed to discern not only similarities and distinctions in language use, but also assign significance according to the contextual features of the conversations (van der Haar & Hosking, 2004). For instance, as Morgan (1997) has pointed out, habituated topics tend to provoke automatic responses, or ones that are not thought out in detail. This was apparent, for example, when I asked participants directly about recovery or the “medical model”. Other issues prompted participants to expand, explain and think more deeply about the issues under consideration. As a moderator, I used prompts and challenges, sometimes directed at individuals, sometimes to the group in order to elicit more critical thought about particular topics.

For example, I remained conscious, even in the early stage of the analysis that not all storytellers are equally powerful. This was the basis of my selection of participants into cohorts, but even then, within groups there were inevitable differences in status, personality and experience. I needed to be cognisant that some people would speak more than others did and some who would remain largely silent. I guided this with skilful moderation, but remained conscious of how my own interests and values might have influenced changes in direction or shifts in thinking. Similarly, interviewees, as senior managers were more likely to offer “sanitised” or preferred stories in the less challenging environment of a one to one interview. These participants were more likely to be conscious of their

role in organisational reputation, and their greater accountability to “how things are done”.

The flow of each focus group and interview was unique. A range of contextual and environmental effects were noticed and remarked on by participants. For instance, two participants commented that they felt constrained because the focus group was conducted in their work environment. This had been difficult to avoid because the organisation had offered the space as an act of generosity. In six cases, focus groups were held with representatives from a single organisation. These included three support worker groups, one each from Auckland, Wellington and Hamilton; two team leader groups, from Wellington and Hamilton, and one peer support team from Auckland. This created challenges as well as opportunities. It was interesting, for example, to compare the differing degrees of organisational identification between groups. In addition, being able to directly compare focus groups and interviews from different cohorts within a single organisation confirmed my sense that distinctions were less about role and status, but more about regions and individual organisations themselves. Comparisons between these single organisation focus groups were also valuable, with participants from one seeming to valorise and identify with their organisation to a remarkable extent at all levels, under a catch-cry of “We’re simply the best”. My field notes described these encounters as “engaging with the glossy brochures”; meaning that these participants uncritically, almost evangelically, expressed the organisations preferred or dominant story. In contrast, participants from the other two organisations were far more critically reflective throughout the organisation and expressed a more genuine sense of working together to grow and make things better.

It was apparent very early on, that people who had a personal history of serious psychological distress or diagnosis utilised a very different and distinct discourse from which to talk about their experiences of recovery. It became useful therefore to single out the five organisations that identified as “service

user”¹⁵ organisations as well as four others that had designated peer support¹⁶ workers, or even peer support teams. In total 29 of the 131 participants identified themselves as, not only organisational members, but also service users (see Appendix 1 for demographic analysis of participants and organisations).

The foremost criticism of appreciative methods, and indeed focus group methods, is that they risk trivialisation and distortion through a Pollyanna-like approach to serious and difficult organisational issues (Fineman, 2006b). Barbara Ehrenreich (2009), among others, raises important concerns about the ideological appropriation of a “positive” discourse by those with economic or political motives for suppressing robust discussion of issues that confront ordinary people in their organisational lives. “Being positive”, in the sense of merely expressing optimistic views, or providing non-critical feedback, on organisational realities, frequently underlines power differences in organisational relationships, and does nothing to solicit dialogue that might expose significant differences in perspectives and “appreciations” of aspects of organisational life. Ehrenreich maintains there are dangerous distortions when powerful interests and systems attribute genuine discontent to individual incapacities to maintain optimism (Ehrenreich, 2009; Fineman, 2006b).

Other criticisms of traditional appreciation methods have included their use and manipulation by those concerned with increasing productivity or compliance. Barge & Oliver (2003) claim that the “true” appreciative spirit in organisations requires those in powerful positions to “to connect with what others value” (p. 130).

Several scholars have criticised the use of focus groups as being merely an expedient way of interviewing several people at once rather than addressing salient features of the group process interactions between participants (Kidd & Parshall, 2000; Kitzinger, 1994, 1995; Morrison, 1998). They have argued that

¹⁵ ‘Service user’ is commonly used to refer to people who have had experiences of extreme psychological distress and been admitted to treatment services at some stage

¹⁶ Peer support is the name given to an identifiable approach, for both individuals and teams whose particular expertise arises from their own experiences of mental illness.

doing so risks missing the divergences of meaning as they shift and emerge from within the group. Barbour (2001) adds that the richness of the data and the analysis is the strength of the method while conformity in the process is often a limitation. However, practical circumstances e.g. conducting a focus group where only two people turned up require cautious and reflective analysis. As moderator, I needed to be particularly careful in such situations, when more active facilitation was required, that I did not overly influence the discussion.

I also needed to remain conscious of two important distinctions between the focus groups and interviews. The first was a potential difficulty that arose because the interviewees were all senior managers; they were prominent in their organisations and had a sense of themselves as authoritative, which was not present in the focus groups (Kitzinger, 1994). I wanted to generate frank discussions and not just elicit the “party line” and there was a risk that these participants drew on an increased sense of responsibility and expectations of their role and status to explain or justify themselves and their organisation. In addition, it was more likely that these participants would use the interview to push a preferred view, unchallenged, and unchallengeable, by an interviewer intent on not alienating a participant (Conger & Kanungo, 1987). Taken in isolation, therefore, the individual interviews could have become opportunities to self-promote as well as to imprint the dominant organisational story.

Second, there was a fundamental difference between focus groups and interviews in terms of the relationships that developed between me, as researcher, and participants (Parker & Tritter, 2006). I wanted to engender a reflective conversation about future organisational possibilities and this was difficult to do in one-on-one interviews without my own perspectives intruding or creating a sense of stage-managing the process. In contrast, participant assumptions in the focus groups were routinely “thrown into relief by the way they challenge each other, the questions they ask [and] the evidence they bring to bear on the issue” (Kitzinger, 1995, p. 301). Although there were fewer opportunities, in the focus groups, to explore individual perspectives in depth, in many ways the interactive nature of the groups achieved greater depth because

they led to deeper thinking and a richer set of perspectives than was possible in an individual interview (Zorn et al., 2006).

A further difference was that I was generally able to create the setting for the focus groups. I set up the room, provided refreshments, had a PowerPoint introduction and some carefully planned interpersonal strategies to put participants at ease the moment they entered the room. None of this was feasible for the individual interviews, which were usually held within the organisational setting of the senior manager or CEO, where I was positioned as a guest.

Possibly the major limitation of this research, from a methodological standpoint, was an inability to generate action and effect organisational change through whole system effort and engagement (Cady & Caster, 2000; Cooperrider & Srivastva, 1987; Fuller et al., 2000; Lewis et al., 2008). Organisational change is an important premise of CAI, but this was just not practical within the scope of a doctoral research project where the researcher was the only participant committed to a deadline, and the research design could not be over-reliant on actions undertaken by other participants. This circumstance was further complicated because participants were not employed by the same organisation or even working in the same region. All of which meant there could be no presumption of practical organisational action or change at this time.

I relied, instead, on the basic premise that these participants and their organisations wanted an inquiry approach that captured their aspirations as much as their problems, and embraced optimism and celebrated success rather than focused on problems and risk. The focus groups and individual interviews allowed us to identify, and stand outside, normalised organisational discourses and to explore questions of “how would things be different if we made other choices?” (Taylor, 2004, p. 113). In doing this, participants were directed to recognise and develop a shared perspective of how transformative organisational change, more critically oriented to their expressed values and vision of recovery, might be achieved. The process also aimed to enhance their sense of agency, and it encouraged them to consider alternative, and more

effective, actions as practitioners and organisations (Barber, 2005; Fuller et al., 2000; McCashen, 2005; Zorn et al., 2006).

In turn, this required my active commitment as research coordinator to create, and engage with, a collaborative space that recognised the wealth of resources that participants brought and allowed them to shape the process in terms of their own priorities. Encouraging participants to “realise their best intentions” was still the overarching aim for the research.

The organisation and analysis of the data

Analysis of the data, regardless of the form of inquiry, is required to be a disciplined process with transparent, systematic and clearly defined protocols. My original methodology and intended procedures had anticipated major distinctions among the cohorts, and I had expected to treat the interview data from senior managers somewhat differently from that of the focus groups. However, in the apparent absence of these distinctions in early examination of the data, and the strength of the emerging themes, I made the decision to combine the data and undertake, primarily, a thematic discourse analysis.

In keeping with my critically appreciative methodological stance, I undertook a critical thematic data analysis. This involved processes focused on identifying the values, perceptions and concepts that participants used to discuss organisational effectiveness and recovery, and how these were communicated through organisational talk, texts and practices. This was accompanied by a critical analysis intent on examining how participants drew from multiple discourses, within the sector and the wider socio-political environment, and what this revealed about the potential for change in organisational and institutional arrangements in the mental health sector of Aotearoa\New Zealand.

Critical thematic analysis

The analysis was thematic in that it was continuously looking for recurrent threads of meaning through the repetition and emphasis of key words, phrases, metaphors and other significant elements and patterns of language use (Aronson, 1994; Braun & Clarke, 2006; Owen, 1984; Tuckett, 2005). As these

emerged from participants' discussions they were carefully assembled to produce a comprehensive picture of their collective experience. Themes were identified by connecting and gathering these narrative fragments of ideas or experiences, and might have been meaningless had they been viewed in isolation (Boje, 2001). Of course, I was interested in developing only those themes that related to the research questions and this served as a continual reminder that the responsibility for the organisation of the data and the eventual coherence of the narrative rested with me as researcher (Leininger, 1985).

In the analysis, it was important to distinguish between talk that was indicative of locally constructed and contextualised discourses, more universal, historically situated vocabularies, and widespread linguistic phenomena that constructed larger socio-cultural discourses (Alvesson & Kärreman, 2000). However, I remained cognisant that indications of overarching themes were also present in local discourses and needed to be carefully summarised and synthesised. A critical gaze further enabled me to compare accounts and discern those that were more powerful in determining the recovery practices of these organisations; while simultaneously seeking alternative discourses that might prove fruitful for transformation to a more idealised recovery orientation. Therefore, it was important in responding to the complexity of interview and focus group accounts to review regularly how I was moving from my encounters with the transcripts to aggregating the elements into summaries and other interpretations of wider discourse sets (Alvesson & Deetz, 2000).

Continual comparisons between the transcripts, the sector texts and an active investigation of the literature reinforced my sense that identified themes rang true for participants as they articulated their experiences. Interweaving the literature with the findings increased my confidence that the story under construction had merit (Aronson, 1994). In building the argument for selecting themes and making inferences I frequently referred to both my original literature review as well as seeking out new literature that helped me understand what was emerging from the data.

This return to the literature provided new theoretical material, specifically literature around institutionalisation and the few examples of scholarship that discussed processes of institutional change and disruption (Oliver, 1992; Maguire & Hardy, 2009; Reay & Hinings, 2005). The literature around translation was also significant as it became apparent that people were utilising language and referring to concepts in multiple ways. (For a detailed discussion of how my initial impressions, preliminary findings, emerging themes and participant feedback that guided the analysis please see Appendix 8.)

Organising the data

The primary data for this project were the transcripts of the 22 focus groups and 16 interviews that I undertook around the country. As each focus group was typically 2 ½ hours long, this amounted to some 1500 pages of transcripts. In addition, as previously discussed, a rich source of secondary data arose from the pre-focus group\interview and post- focus group\interview forms, as well as the transcribed field notes I had recorded immediately after focus groups and interviews. I also drew on a body of supplementary documentary or textual data that included national, and sector, strategy and policy texts (see Appendix 5 for a full list of these texts), as well as organisational material such as mission statements, websites and other promotional material whereby organisations identified themselves with their values and other discourses around mental health.

Each of these data sources was useful for explicating the relationship between preferred organisational and sector stories with the everyday realities of their organisational practices. However, the distinctions I had expected between cohorts were not as evident or dramatic as anticipated and it was clear that a comparative analysis among these groups was less significant. Therefore, I now needed to decide how to treat focus group and interview data. The primary concern was not to create an inadvertent hierarchy of data, with some methods considered more “accurate” or significant. This was an important consideration given the comparatively higher organisational status of senior managers; a status that generally gave them a more strategic view and for whom the environment

of an interview had offered a greater opportunity to produce a coherent narrative. In the event, I was more likely to privilege the voices and perspectives of workers within focus groups as more “trustworthy”, if only because their views were open to challenge and debate and ultimately more collaborative in their iteration.

Collectively these data sets comprehensively addressed my research questions and provided insights into dominant and alternative narratives as well as discerning the levels at which they functioned and their relative power within organisations (Bleakely, 2002; Bruner, 1991; Connelly & Clandinin, 1990; Fuller et al., 2000). The combination of data sources and data gathering methods also provided a form of triangulation that made the analysis more robust and rigorous (Lambert & Loiselle, 2008).

The focus group discussions and interviews were recorded and then transcribed by a paid transcriber. Each participant was assigned a unique code that identified which focus group, cohort and region they came from. The code also identified whether they had participated in a service user focus group or one that involved a single organisation. I utilised both the electronic and hardcopy versions of the transcripts to undertake an initial eyeball analysis. I created a cover sheet to attach to transcripts that allowed me to note key words, key themes and the overall direction each focus group or interview took. Simultaneously, I began coding the data using some of the surface functions of MS Word such as highlighting text and adding comments as I read and re-read the transcripts.

I read and re-read the transcripts and developed my field notes in conjunction with listening to the digital recordings. This provided me with an early appreciation of the richness of the data (Boyatzis, 1998; Miles & Huberman, 1994). I made comments onto the cover sheet of each transcript and, through these, I built up a set of narrative fragments that began to identify significant language use, key themes and units of meaning (Boje, 2001; Miles & Huberman, 1994).

These first readings, colour coding and notes also enabled me to categorise and collate data into three documents that incorporated material relevant to each research question. Where data overlapped, it was included in both documents. This focussing process also allowed for overall reduction of the data set with material not pertinent to this project parked separately for future work (Miles & Huberman, 1994; Boyatzis, 1998). The categorisation enabled the emergence of a data display and an early theme schema that more coherently drew together significant ideas and the relationships among them (Miles & Huberman, 1994). These were entered into tables, one for each research question (see Appendix 7 for emergent themes).

The collated and summarised post-focus group\interview forms provided an exploratory identification of key themes and helped me develop a feel for the boundaries of my research questions (Appendices 6, 7 & 8). The forms provided a starting point for comparing the focus group discussions about what was working well in their organisations and what the next steps towards recovery might look like. They were also very important, reflexively, for confirming that participants had felt heard. In addition, the field journal notes were a record of my immediate and overall impressions: the noteworthy characteristics of each focus group or interview, my thoughts, interpretations, questions, and directions for further data collection (Strauss & Corbin, 1998).

Focus group data can be assembled and compared in different ways each with different potentials for revealing data patterns. Therefore, I needed to make selection choices to ensure that the data yield did not become unmanageable. At the same time I needed to ensure that comparisons and interpretations explored sufficient themes, including significant absences, to produce meaningful discovery. The themes that emerged were compared among focus groups and interviews and coded by cohort and region. Notable quotes and comments were identified and marked for easy reference. The transcript data were also compared with some current and historical texts to tease out the ways in which recovery and other important discourses were being framed across the sector (Aronson, 1994; Tuckett, 2005).

National and sector texts (for full list see Appendix 5) provided the historical framework of national mental health policy and strategy over the last fifteen years and anchored the contexts of the study. The vagaries of the relationships between community mental health NGOs, the various Ministries of Health and their nominated funding bodies over that time were of interest, as was the changing nature of the socio-political environment.

The aim was to uncover some of the interpretative struggles (Mumby, 2005) around the discourses of recovery within these organisations and at the boundaries of their interactions with wider social discourses such as biomedicine and managerialism (Phillips et al, 2004). This meant developing an iterative strategy that moved back and forth between examinations of the raw data to summary descriptions and then to interpretations that suggested important meanings. This led to a final, critical analysis that examined the implications and significance of these themes for the sector and mental health services as a whole. The early analysis guided the substantive thematic analysis and provided confirmation of the appropriateness of the inquiry methods and investigative direction (Appendices 7 & 8).

Conclusion

Barge and Oliver (2003) have suggested that becoming appreciative, in terms of organisational and management practices, means taking account of what others within the organisation value, becoming reflexive and thereby gaining a deeper *appreciative* understanding of the organisation, its stakeholders and the multiple social, cultural, political and economic factors that influence its growth and development. Critically appreciative inquiry as a methodology resonated with the other important structural and theoretical elements of this project; it included eliciting a range of voices and perspectives as a means of uncovering alternative ways of conceptualising organisational processes, especially in terms of a recovery orientation.

Resonance was also achieved methodologically through the criteria for rigour for naturalistic inquiry, first explicated by Lincoln and Guba (1986). These criteria

include principles of fairness; that constructions of all stakeholders were represented with equal power. Similarly, “ontological authentication” (p. 82) was crucial as I needed to represent the new consciousness, of the participants and myself, of the complexities of their social, political and cultural world. “Educational authentication” (p. 82) was also evident as participants gained enhanced understandings of the realities of others while the whole project engaged in a kind of “catalytic authentication” (p. 82), by virtue of a collaborative activity that gave voice to the previously voiceless.

Focus groups and semi-structured interviews were effective in facilitating conversational and collaborative discussions that uncovered the language tools, assumptions and rationalities that determined local and organisational conventions of what was considered appropriate and relevant to discourses of recovery and other social values. The methodological choices were also important for attending to participant talk about the relationships between their organisations and society as well as other normalised discourses.

The data from focus groups and interviews provided some powerful but unanticipated insights. I had expected that my analysis would expose tensions among recovery and other, dominant, social discourses such as biomedicine and managerialism. However, I quickly realised that I had gathered important narratives that described what happened to an alternative discourse such as recovery when it endeavoured to become established within a heavily institutionalised field such as mental health (Maguire & Hardy, 1999).

In the chapters that follow, I present the analyses of my findings organised around each of my research questions. The first chapter addresses the first research question and is concerned with participants’ constructions of recovery discourses and their expression in community organisations. I entitled it *Lost in translation: Negotiating the discourses of recovery* and this explores how participants constructed experiences of “madness”, or mental illness, and the implications this had for their discursive constructions of recovery. These were primarily issues of voice but also exposed the different rationalities underpinning different discourses.

The second findings chapter, *Encountering the institutions* is concerned mostly with the complex features of institutional power and the implications this has for their persistence and legitimacy, as well as their influence over less authoritative discourses and the community mental health organisations. The earlier examination of the problematics of organising and the relationship between organisations and the state is particularly pertinent here. Participants were less articulate about these aspects of their organisational realities but regularly expressed frustration around the ways recovery was being enacted in their relationships with the DHBs.

The third findings chapter, entitled *Fighting back: Struggles and innovations* is concerned with the ways that participants endeavoured to problematise and disrupt the institutional discourses of biomedicine and managerialism and establish alternative discourses of recovery in their organisations' practices. It also examines the evidence of defensive institutional work, in particular discursive strategies such as translation as these institutions sought to maintain their legitimacy and power.

Chapter 6: Lost in translation: Negotiating the discourses of recovery

Those who do not have power over the stories that dominate their lives, the power to retell them, rethink them, deconstruct them, joke about them, and change them...truly are powerless because they cannot think new thoughts.

Salman Rushdie (1991, p. 480)

Introduction

In this chapter, I address my first research question: In what ways are discourses of recovery constructed, negotiated and resisted within non-government community mental health organisations in Aotearoa\New Zealand? In what follows I explore how recovery is being *organised*, in terms of practices, measures, outcomes and relationships within, and among, the community organisations and the wider mental health sector. This analysis revealed the many tensions among different parts of the mental health system. It also demonstrated how struggles for control of the meanings of mental health and “illness” have been, and are still, evolving. In particular, those participants who had their own experiences of psychological distress or even identified as “service users” while working concurrently in these community mental health organisations, constructed narratives of madness and recovery very differently from other participants. These constructions also underlaid how they understood the work they did within their organisations (see Appendices 7 & 8).

Therefore, I first critically examine the constructions of, and distinctions between, experiences of madness and mental illness in terms of the problematic of voice (Mumby & Stohl, 1996, 2007). Second, I explore the significance of these distinctions in terms of recovery discourses evident in the talk of participants; I also examine how it is being constructed in important texts. I then attend to what an “ordinary” life in community meant for participants. This is

followed, with reference to the problematic of organising (Mumby & Stohl, 1996, 2007), by a discussion of how participants and texts constructed recovery-oriented services in the mental health sector.

Finally, I draw on the theoretical lens of translation to examine the implications of multiple meanings, conflicts and tensions in the language and concepts utilised by participants, as they negotiated multiple discourses and managed the transfer of ideas across organisational boundaries and throughout their organisational interactions (Cooren, 2001; Maguire & Hardy, 2009; Venuti, 2004).

Stories of madness

The initial analysis of the transcripts exposed some powerful, but somewhat surprising, features. This was exemplified by a remarkable distinction between subjective “models of madness” (Read et al., 2004), and a reified construct of “mental illness”. Participants with their own experiences of “going mad” echoed literature that challenged the primacy of a biomedical story of their “illness” and experience. This inconsistency was clearly well known to, and taken for granted by, these participants and they talked about madness in very different terms from other participants.

Participants with their own experiences of serious psychological distress described what they had undergone as overwhelming, intense and unmanageable at the time. However, they were clear that this was also a profoundly human experience that had value and meaning. They frequently struggled to come to terms with a powerful experience for which they had lacked the skills and tools to manage at the time. But, they were concerned to make meaning from their experience in ways that could enhance their understanding of themselves and their aspirations for life in general.

For them, any discussion of recovery was inevitably grounded in these personal stories of madness, which were narratives that began in the past and

moved into the future. Their histories and contexts were vital in making sense of the ways their lives and aspirations for the future had changed.

The power of story

The personal experience of “going mad” was integral to constructions of recovery for people with lived experience of serious psychological distress. They used metaphorical, emotional and evocative language, with which to discuss their experiences of both madness and recovery. Discussions of recovery were inevitably grounded in the madness story, and contrasted markedly with other participants for whom the experience itself was either peripheral or went unremarked. This contrast is evident in the pair of quotes below:

Any illness can, does, set a person back, it can physical, mental, or health wise, it will set your abilities back, but it is having this ability to accept that yes I am unwell, and yes I cannot cope with my housework, no matter what the cause is, it is being able to call on other people for help

(Team Leader 1, Focus Group A, Hamilton)

This acceptance of deficit and disability contrasted strongly with the perspective of a senior manager in Wellington, who had his own experience of psychological distress:

There also needs to be something around having respect for the experience, it is not something that is just a deficit [. . .] Actually it is a really powerful dynamic huge experience that it is so powerful that actually there is an element of respect or even awe of the experience, how big it is, and it is really important for us when we interact with people to actually have that sort of respect for the experience.

(Senior Manager 1, Wellington)

For workers with lived experience the expressions of their experience and symptoms were ultimately communicative events; ones they struggled over time to understand the meaning of and often needed help to come to terms with.

This came with the awareness that “people are not out to create havoc for themselves to make your life difficult” (Senior Manager 2, Wellington). Instead, it was important that other workers recognised that there was a reason behind people’s behaviour and that making sense of what they had been through and where they had come out *was* recovery for these participants. Learning and re-learning about their sense of self, others and a life that was profoundly changed after their experience was vital for them in managing their lives and envisioning their futures.

The stories of others

The power of personal stories was central to resistance of the dominant medical stories based on an assumption of organic disease. In general the workers who had personal experience of serious psychological distress rejected the reification of their experience as mental illness, and were reluctant to discuss it in those terms. As one person expressed their experience:

. . . sadness and anger, and maybe sexual abuse, and maybe violent abuse, bullying at school, or trauma in your childhood, and it is not actually bi-polar [disorder] it is all the feelings behind it.

(Support worker, Focus Group A, Wellington)

The disconnect between people’s own explanatory models and the diagnosis they were given literally “didn’t make sense” to people. Most completely dismissed the biomedical pathologising, dehumanising and categorising of what they had been through. Participants echoed this sense repeatedly:

I think you have got to have some really important assumptions, and I think that there [are] assumptions around what is crisis, you know. I think of crisis as a critical learning opportunity really. It is a learning opportunity that is forced on you, because if you don’t learn you are going to die in some way.

(Senior Manager 3, Wellington)

They also rejected the biomedical perspective that what they had gone through was unequivocally negative and valueless; their experience was merely problems, symptoms, behaviours and emotions that needed to be fixed or brought under control. As a peer support worker from Auckland commented:

All these so called symptoms are just human experiences that exist on a continuum, and when you have been given that diagnosis, it just means that you have ended up down one end of the continuum, but it doesn't mean that it is not a normal human reaction, because it is.

(Peer Support 8, Focus Group PS, Auckland)

Most anxiety was directed to the dominance of the medical story and the fact that clinical professionals discounted their own thoughts and explanatory models. Diagnoses also changed frequently, and this was more often due to changes in personnel in the clinical team rather than any new information being incorporated into their assessment. These participants were far more concerned with the social and psychological factors that had led to their experience, many referring directly to patterns of trauma or abuse that in conjunction with other life circumstances had proved overwhelming at some time or other.

It was important to this group to resist the identity imposed on them by the label of being mentally ill and to claim a more valued identity for themselves, especially within mental health services. They felt dehumanised, devalued and mistrustful of the biomedical explanations of their circumstances as well as the biological and physical treatments that were inevitably associated with it. There was an inevitable sense of loss of human and social connection; of self-esteem and confidence that came with their experiences, many associated with the harmful effects of clinical treatment itself. Accepting or submitting to the biomedical interpretation was clearly seen as a form of surrender to something ubiquitous and powerful; this had serious and adverse consequences for people:

It's the labelling of course, human beings are good at that, oh so and so is this, or is that. Classifying people into a mould almost, yea, and all that is associated with that. So once you

become a diagnosis you lose a sense of self-worth and if you take on that role of the diagnosis, a label that someone's put on you, you begin to act and behave accordingly.

(Team Leader 1, Focus Group A, Hamilton)

Other serious consequences of the biomedical story included the persistence of their recorded history in clinical mental health services. Some referred to this as like having an indelible tattoo, and labels that were 30 years old, such as "a history of aggression", still followed them through the system whether appropriate or even accurate. Some commented that even police records do not go back that far. Although these comments could be removed from a person's clinical history, it required an active request and the agreement of the current clinician. An exchange amongst support workers in Wellington typified the frustration many felt:

From a recovery focus, you have to be able to move on and not keep on being reminded of what happened in the past. If I got reminded of what I did 10 years ago. That is a stigma, stigmatised.

(Support Worker 8, Focus Group A, Wellington)

Similarly, in a Hamilton group, support workers discussed the general reliability and accuracy of referrals the contents of which were, nevertheless, preserved, disseminated and acted on as fact:

Only about a quarter of them have told the truth, and it is like "Oh my god I am with this dangerous criminal [. . .] am I safe?" Oh yes, and I read here he shouldn't be left alone with a woman. Okay I have to go in there, but when you get behind that . . . some of it is so historical, he could be like a 60 year old and this happened when he was 15, and it never gets dropped off. And even your criminal record goes after so many years

(Support Worker 2, Focus Group B, Hamilton)

Clinical records, by contrast were typically stories that included diagnostic and needs assessments, daily notes, incident reports, discharge plans and referrals. Not only were these “stories” told from one, usually biomedical, standpoint but they were invariably deficit and problem focussed; solely a record of negative “incidents” that required intervention or treatment. Many participants reported this as unbalanced and demoralising:

(PSW 2) It is the diagnosis a lot of the time that just finishes you off; oh well they have got that, that’s it. For some people it is great the diagnosis, “Oh okay this is what is wrong with me”, but then for other people it is like a death sentence.

(PSW 3) Especially when they get it wrong

(PSW 2) And they tend to get it wrong all the time; 90% of the time it is not really what it is

(PSW 4) And it follows you around for 20 years.

(Peer Support workers 2, 3, 4, Focus Group PS, Auckland)

There appeared to be no room in the clinical story for contextual information of personal resourcefulness or circumstances. The *before* of people’s lives prior to entry to the service was outlined, if at all, in the clinical referral forms and discharge plans. This left no legitimate space to talk of the experiences themselves, let alone establish an inventory of people’s strengths, supports and resources, thus naturalising further the biomedical account.

Because clinical stories were so thin, they were also open to multiple interpretations. In one Wellington focus group, participants recounted a story about a young man who had been described in assessments and referrals as being “aggressive to women” (Support Worker 1, Focus Group A, Wellington). This was apparently based on a single incident in his early teens when he was in conflict with his mother. Not only was her version of events the only one on record, but this information was forming part of referral reports several years later. An excerpt from this conversation follows:

(SW1) Somehow it's generalised towards the entire gender,
when it should only be focused on that one person

(SW7) Because she was a bitch

(SW1) Yeah

(SW7) And it wouldn't state that the mum was aggressive
towards him

(SW1) No that is a very good point

(Support workers 1, 7, Focus Group A, Wellington)

The dominance of arbitrary, clinical judgements meant referral reports were a contentious issue for many participants. Some, from a range of organisations, spoke of refusing to read referrals until they had met a person themselves. But significantly, others including a few service users considered knowing a person's history as described in referrals "as vital information" (Support Worker 1, Focus Group H, Hamilton), reflecting the dominance of the clinical story.

People were equally scathing about clinical responses to madness; they were critical of most treatments and, in particular, medication. This was an issue echoed in significant national texts such as *Te Hononga 2015* (Mental Health Commission, 2007b) which explicitly outlined a vision for the future where "medication will be recognised as causing significant harm as well as providing significant relief in some cases" (p. 14). But its inclusion as a future aspiration reinforced participant talk of frequently inappropriate and inadequate responses to their distress. As one peer support worker in Auckland described it:

And it can be so in-depth - the causes, the trauma that you
can't even talk about because you haven't got the words for
it and it is like how is medication going to help that.

(Peer Support Worker 5, Focus Group PS, Auckland)

In addition to being ineffectual and inadequate, it seemed clear that many treatments were experienced as actively harmful.

First do no harm

Participants with personal experience of serious psychological distress were also the only ones who explicitly referred to the iatrogenic, or harmful, effects of being in clinical treatment services. There were many references to the service users they worked with being afraid of, and avoiding, clinical treatment services; of being “locked up in hospital” (Peer Support Worker 6, Focus Group PS, Auckland); even diagnosis being a “death sentence” (Peer Support Worker 3, Focus Group PS, Auckland). Similarly, these participants themselves frequently experienced diagnoses and concomitant treatment regimes as unhelpful. This was largely unremarked by others in focus groups and completely absent from national documents such as those generated by the Ministry of Health (2005a) and the DHBs.

In addition, the effects of treatments and hospitalisation were seen as significant contributors to the difficulties service users encountered in managing their lives. Sometimes these were the overt side-effects of medication and other treatment regimes; but participants also reported secondary effects of depression, hopelessness and extreme loss of self-confidence that were the consequence of others taking control of their lives and the systematic dismissal of their own thoughts, feelings and opinions. Recovery became, in this sense, as much to do with recovering from how the biomedical model was “done to” people, as from their original experiences of distress.

By contrast, other participants, without personal experience of serious psychological distress, rarely mentioned the experience and circumstances of madness that was so central to their colleagues understanding of the work they did. Most non-service users within these organisations appeared to have absorbed as commonplace the idea that recovery only began when a person entered services and created a documented record of assessments and measurements of progress. There were important exceptions:

Giving people time and listening to their story because the people we work with have the most amazing stories and they don't often get the opportunity to talk about them, and to

talk about who they are, people don't want to know
(Team Leader 3, Focus Group W, Waikato)

Telling their stories was clearly very important to people with lived experience of psychological distress and several organisations acknowledged this in their policies. A senior manager from an organisation that had strong service user leadership remarked that “everything; symptoms, behaviours [is] communicating something” (Senior Manager 5, Wellington) and people needed to be invited and encouraged to talk about the issues facing them. Another organisation that had explicitly adopted Charles Rapp’s strengths model¹⁷ (Rapp, 1998) used entry interviews to ask questions about a person’s life “before mental illness” in order to provide clues to potential aspirations and goals a person might want to work towards. A third, which had embedded a Peer Support service¹⁸ deeply within its overall organisational structure, recognised the importance of people being able to tell their story in a safe environment if this is what they wanted.

Nevertheless, many participants reported that there was also considerable fear and mistrust expressed by service users; that talking about their experiences to service workers could lead to a roller-coaster of interventions and loss of control over their decisions. As one participant pointed out, “I have found that a lot of people are not talking about what they are experiencing because telling you what they are experiencing means that they get judged or occasionally pre-assessed; something [gets] done to them” (Senior Manager 5, Wellington). This was contrasted with the advantages of Peer Support services, where “they don’t have to feel like they are taking a risk, that the story will be taken away” (Peer Support Worker 2, Focus Group S, Christchurch).

¹⁷ Note the Strengths Model, as developed by Charles Rapp (1998) is not the same, although frequently confused with, strengths based practice that was initially developed by Walther Kishardt and others (Barber, 2005; McCashen, 2005; Weick et al., 1989)

¹⁸ Peer Support services, available in a few DHB catchments, are based on the shared experiences that peer support workers have with service users.

Participant stories of madness illuminated the tension between the biomedical story of diagnosis and symptom control, with the lived experience and aspirations of people who have suffered episodes of extreme distress. These accounts exemplified challenges that service users encountered in services, in endeavouring to resist biomedical models and substitute their own explanatory models over several decades. The bio-medical story not only involved reifying diagnosis but also discursively closed down, and decontextualised the human experience of psychological distress. At its heart, the conflict appears to be with a construction of experiences as wholly negative and valueless versus one that has intrinsic communicative value, and from which people can learn, grow and aspire to a more hopeful future.

Stories of recovery

In this section, I examine how all participants defined and talked about recovery within the context of NGOs in Aotearoa\New Zealand. While the data did not provide a single “true” or authentic discourse of recovery it was apparent that different discourses served different interests and functions that had implications for organisational practices and the ways that services were delivered in this country. It was also interesting to note what was, and what was not, talked about by participants in these conversations. The critical distinction, again, was between how participants informed by their personal experience of serious psychological distress and recovery talked, in contrast with other participants who continued to rely on definitions and descriptors that appeared in national policy and strategy documents such as the *Blueprint* (Mental Health Commission, 1998). Other significant thematic distinctions were apparent in how participants drew on vocabularies of empowerment or independence, aspirations or goals and how these were incorporated into organisational policies, practices and processes about recovery.

(Re)defining recovery in Aotearoa\New Zealand: Discovery and rediscovery

Although recovery was inevitably positioned as the antithesis of the medical model, it was nevertheless constructed and negotiated in several

different ways. All participants were aware that the significance of recovery was that it had “arisen because the medical model does not work a lot of the time” (Team Leader 2, Focus Group A, Christchurch). And while the need for an alternative paradigm was acknowledged, some commented that it was “a shame we have to have a name or model or a philosophy in order to treat people with respect and dignity” (Team Leader 3, Focus Group A, Christchurch). Many were aware of the historical and political context from which it had emerged. For example:

In terms of the terminology I think that [recovery] has been a bit of a buzz word and in some ways it has been a response to statements like “severe and enduring mental illness”, and the tyranny of that over people’s lives [. . .] for a lot of people it is recovery from that impression.

(Senior Manager 3, Wellington)

There was a good deal of congruence among participants from within the same organisation. This was especially noteworthy where organisational leadership teams clearly articulated their personal, as well as organisational, values and models. Participant stories of recovery were generally founded on the same ontological basis, of subjective human experience, as the stories of madness to which they corresponded. However here the boundaries were more blurred and multiple meanings were evident:

Recovery is not about a cure, it is not about, necessarily, about getting rid of the symptoms. [We] really hope that people have less distressing symptoms, but that may not be the reality. So you have recovery as a paradigm, you have rehabilitation as a paradigm, you have cure as a paradigm, and recovery overlaps them but it is not them.

(Senior Manager 4, Auckland)

The talk of those participants who worked in organisations whose organisational evolution was strongly informed by the experiences and voice of people with lived experience of serious psychological distress was distinctive. In

contrast with many other participants, this group discussed recovery in ways that were inevitably richly nuanced, organic, and thoughtfully articulated. It was frequently talked about as coming to terms with a new self, rather than a return to an old way of being in the world. There was little sense of recovery meaning “getting back to where they were before”. Instead, there was certain hopefulness and optimism for a new future:

So it’s perhaps getting to a new place, with some of those things that you had before. But also, the lessons you’ve learnt through the process or journey.

(Senior Manager 4, Hamilton)

For participants with personal experiences of madness and recovery, the process of recovery was to make sense of it; to learn from it; to find meaning and value in it that would transform their sense of being in the world. Others maintained it was less about *re*-covery and more about *discovery*. As a participant from Auckland explained:

It is not about recovering because that indicates that there is something wrong with you; there is not necessarily anything wrong with you. You have been through some tough stuff and it has had this effect, and you have not had the tools to deal with it, so it is about discovering the strengths about yourself and discovering the tools you can use to live your life better. (Peer Support Worker 6, Focus Group PS, Auckland)

On the other hand, many participants who had not had lived experiences of serious psychological distress frequently referred to stock definitions and repeated the phrasing of the definition that prefaces the *Blueprint* (1998) when asked what recovery means to them. For example, this definition by a support worker was typical:

[It] is about being able to live well even though you have an illness or a disability or a medical condition that might hinder

aspects of your life.

(Support Worker 1, Focus group C, Hamilton)

This regurgitation and the unthoughtful reproduction of statements, such as “living well in the presence or absence of illness” (Mental Health Commission, 1998) and, “It’s a unique, individual journey where people achieve their goals” (Support Worker 5, Focus Group P, Hamilton), seemed to indicate that the thinking around recovery had not developed over the last 15 years for many people. Nor was it deeply embedded within many organisational discourses and practices. These participants also seemed to think recovery was a taken-for-granted, almost outmoded concept, without appearing to recognise the inherent contradictions in their comments about recovery, and organisational practices.

All participants exhibited a good deal of empathy with service users, but their thinking about recovery appeared to have stalled in the face of more pressing organisational requirements such as “risk management” and “clinical oversight”. They expressed considerable frustration with the constraints put on them by clinical teams and DHB funders and they could see that these were antithetical to individualised and flexible approaches to supporting a person’s recovery:

[The] medical model is about risk management rather than [recovery], so the doctors want to see that the patients are taking their medications and they have had a reduction in symptoms and that.

(Support Worker 6, Focus Group P, Hamilton)

Despite these tensions, and sometimes contradictions, in their organisational environments, almost all participants used a journey metaphor to describe their notion of recovery. However, compromises were evident in the ways that recovery “journeys” were constructed in terms of organisational practices.

The nature of journeys

Workers who also had lived experience of serious psychological distress described the journeys of recovery as stories that had beginnings as well as destinations, and invariably looked back to the experience of madness. Their history and context were vital in making sense of the ways their lives had changed and their aspirations for their future:

I used to think recovery meant being like you were before you struggled with something, and I spend years trying to get back to that, and eventually when I realised - to accept that I am never going to be the same, but I can be different and be, yeah, better and be a lot richer, that is when I started to recover. Yeah I am always going to be a worrier and the rest of it, but I can manage this and it doesn't have to like drive me, whereas I am in the driver's seat a bit more now.

(Peer Support Worker 1, Focus Group PS, Auckland)

For these people recovery was ultimately a journey of transformation; a journey that has *stages* rather than *goals* (Senior Manager 3, Wellington); each of which required a thoughtful and distinct response and that needed to be taken in order with "first things first". For these participants what was required was an awareness of where a person was at; "that everyone is doing the best with information and the skills that they have at this time" (Senior Manager 5, Wellington). There was no expectation that these would be linear, or straightforward, journeys. As one person put it:

It is a sort of a process; it is something that is continuous and dynamic and changes all the time. And just because, it doesn't end so it doesn't continuously get easier and easier. It can have waves, it can have loops, it can have wiggles.

(Support Worker 3, Focus Group A, Wellington)

The key distinction about the nature of journeys was that, for workers with their own experience of serious psychological distress, recovery journeys

were about learning and personal transformation. Others echoed similar sentiments:

The recovery journey is unique [and it is] a huge thing, yeah it is endless and there is so much learning to do, and growth to do. (Team Leader 4, Focus Group W, Waikato)

For participants and organisations less informed by the voices of people with personal experience of serious psychological distress, the metaphor of the journey was ambiguous. Some disparaged constructions of recovery as being merely a service requirement and for nearly all of these workers and organisations the *journey* of recovery seemed to begin only when people entered services with a documented clinical referral and documented expectations of carefully measured progress.

Many participants acknowledged that recovery journeys take time and expressed frustration at unrealistic expectations that “after a lifetime of experiences, [clinical] services want a 5min fix” (Team Leader 1, Focus Group P, Hamilton). They also understood that learning necessarily meant that people would make mistakes and needed encouragement to learn from these. This was often thwarted by contracting and other service policies. This exchange was from a team leader focus group in Hamilton:

(TL4) Recovery IS making mistakes - going back and forth, continuing to do that until they decide that it’s not . . .

(TL5) Services lack tolerance

(TL4) Getting “chucked out”, “Don’t make mistakes or else”.

(Team Leaders 4, 5, Focus Group P, Hamilton)

But participants who had personal experiences of distress were insistent that recovery journeys were natural processes that could be impeded by inappropriate intervention. “Everybody recovers from things if the environment allows them to,” remarked a Wellington senior manager (Senior Manager 5, Wellington) and this was echoed in an Auckland group with the comment that “people may not know what they want half the time; but they know what they

don't want" (Peer Support Worker 5, Focus Group PS, Auckland). In general, the consensus seemed to be that a successful recovery was "reaching a place within you in your life that is right for you, and positive for you, and I sort of see it as gaining peace of mind." (Peer Support Worker 6, Focus Group PS, Auckland)

How workers and organisations responded to the realities of a person's life circumstances appeared to correlate with their underlying ontological and socio-cultural positions on the experiences of madness\mental illness and recovery. It seemed that there were different socio-cultural expectations of people using mental health services than of the general population. As one senior manager commented, with some irony,

I didn't learn the first time I had a hangover. I know that is shocking. It probably took me a good thousand hangovers before I suddenly realised that hangovers weren't such a good thing. We are only part of the journey for a service user.

(Senior Manager 3, Auckland)

Many participants articulated this ideal of being supported to learn through the inevitable ups and downs of a recovery journey; although this was often accompanied by a sense of frustration at being constrained by other service and environmental requirements.

Empowerment, autonomy and "independence"

One of the most significant aspects of recovery for workers with personal experience of serious psychological distress was the idea of self-determination over their lives. This was variously expressed, in the literature as well as focus groups and interviews, as empowerment, autonomy, *tino rangatiratanga* (self-determination), or personal power. Personal power was defined in *Destination recovery* (MHAC, 2008) as "achieved when people experience hope, purpose, self-agency, a positive identity, a sense of achievement and satisfying relationships" (p. 29).

Regardless of the language used, for this group the concept was used to signify the power to make important decisions and choices about the way they

lived their lives. Autonomy was a word used by participants to indicate a need to be in charge of their own lives. It was founded on the idea that people had expertise and understood themselves and what worked for them best. Even where this was not yet the case they asserted the right to make their own mistakes and learn from them:

(PSW1) It's the autonomy, giving people the chance to find themselves. To step out and make mistakes without being told well that's it you have failed. Being able to learn those mistakes and move out from them, finding yourself and what suits you

(PSW7) Getting to know who you are and then having the confidence to learn to stand by that, and learn to be assertive enough to listen to what you need in life, not always what everybody else needs.

(Peer support workers 1, 7 , Focus group PS, Auckland)

However, it is also important to note that notions of autonomy and independence served particular ontological positions and socio-cultural expectations, and these were sometimes conflated. For workers with lived experience of serious psychological distress, empowerment, or the right to autonomy, was clearly a site of resistance to the power and authority clinical teams and other services maintained over significant aspects of their lives. On the other hand, empowerment, for example, was open to some very loose interpretations that illuminated, albeit unintentionally, the underlying dynamics of power relationships. For instance, one Hamilton team leader made this revealing statement:

We talk a lot about empowering people but sometimes people don't want it; they just want to do what is required you know. We instil this momentum of empowerment, [but] sometimes they just haven't the energy to actually fill out

that form or that sort of thing you know.

(Support Worker 1, Focus Group P, Hamilton)

There was considerable tension between a sense of autonomy that indicated reclamation of personal power and the subtle translation from that into “independence” that was central to most service contracts and organisational cultures. Independence seemed to mean both an individualistic emphasis on “doing things for themselves” while maintaining a traditional service ethic of paternalism and authority. This translated the notion of personal power and resourcefulness into service expectations and pressure. For services, what remained unchanged was the locus of power in decision-making. There were varying levels of consciousness of this tension as the following remarks demonstrate:

Independence [clinical key workers] push for, and I keep saying it is inter-dependence, none of us could live out there in the way they are expecting our guys to be living out there, none. (Team Leader 3, Focus Group A, Hamilton)

And then in an Auckland group:

Somewhere down the line we have to teach them independence as well because we are not going to be there for them all the time as well.

(Support Worker 1, Focus Group B, Auckland)

In many cases, it appeared changes in the contracting environment that encouraged independence were more about devolving service responsibility and cutting costs rather than facilitating true choice or increasing personal power over peoples’ lives. This was the case when a Waikato team leader referred to a “magnificent piece of work” that reduced the need for staff sleepovers. She framed this as “identifying what [we] *don’t* need to do” (Team Leader 3, Focus Group W, Waikato) and better “managing risk”. But in the end, this was about meeting service needs and controlling organisational decision making, rather

than any obvious increase in personal autonomy for service users. She further justified this stance, as others did also, by stating:

How long has [he] been in the service, over 13 years? And often it is about that very thing, are we creating dependence or independence, because everybody might be fine, but some of the time, most of the time, in an inverted way, by wanting to do good, we do things for people that they don't need. (Team Leader 4, Focus Group W, Waikato)

These statements served to blur the boundaries of exactly whose needs were being met in services and were invariably based on a presumption of service benevolence that thinly disguised the unilateral exercise of power over people's lives. People who had experienced services first hand roundly challenged this assumption; but other participants routinely utilised these translations of recovery without seeming to be aware of how these maintained many of the traditional ways of delivering services. Several told stories of people's independence couched in terms of supermarket shopping, budgeting and housework.

Similarly, there was no simple binary opposition of *independence* and *dependence*. For workers with their own experiences of serious psychological distress, "dependence" was framed as disempowerment, and clearly, an issue related to services themselves. For example:

[Recovery is] not fostering dependence at all in any way; it is not babysitting, it is not taxi driving, it is not rescuing. It is walking alongside and supporting for them to get where they want.

(Peer Support Worker 3, Focus Group PS, Auckland)

In contrast, other participants translated dependence as a sign of weakness or *neediness* on the part of service users. This was compounded by a general lack of acknowledgment that much, so-called, dependent behaviour was due to the iatrogenic and institutionalised effects of previous service

expectations and treatments. In other words, that the rules may have changed but positions of power and powerlessness remained the same; it was still the service organisations that determined how “the game” would be played.

Both workers with lived experience of serious psychological distress and others, including some senior managers, emphasised that self-responsibility was an aspect of self-determination, and this was necessary for regaining the normalcy and “normalising” of everyday life:

Recovery is [. . .] having as normal a life as possible but as we all know a normal life isn't just getting what you want; it is getting some of the things that you want and a lot of the things you don't want that are not so bad when you get them anyway. So it's normal opportunities to succeed, fail, be happy, be sad. To me that is recovery and it is not having the stigma of mental illness or anything else sitting over your head that actually automatically excludes you from certain things. (Senior Manager 3, Auckland)

It was evident that the perceived opportunities for genuine open-ended choice for service users were limited, and participants and their organisations struggled with this. Restricting meaningful choice and decision-making in their lives was also acknowledged as having a negative impact on people's motivation and capacity for self-determination. Constructions of recovery, by people with lived experience of serious psychological distress, emphasised the importance of feeling in control of important aspects of their lives. As one senior manager put it, “If you don't have ownership you don't care” (Senior Manager 3, Auckland). Instead many participants commented that their “clients don't get to make their own decisions about their own lives which is really horrible” (Peer Support Worker 3, Focus Group PS, Auckland). Although this was a pragmatic reality for organisations, under the contracting umbrellas of their DHBs, it clearly concerned most participants.

However, several participants noted that living a life of choice had little relation to nominal notions of “normality”. In fact, they echoed Patricia Deegan

(1996) in suggesting that communities and societies needed to broaden their criteria of acceptance and tolerance:

For most outside people, his life would look quite chaotic and very, very different. But the fact that is he able to do it in his own home and able to make his own decisions, he can eat what he wants, do what he wants. His recovery to the outside world would look, you know probably quite wacky, but hey he is doing it his way and he is enjoying it; it works. I see that as recovery, whereas a lot of other people probably think he has a long way to go, but hey, he is doing well.

(Team Leader 2, Focus Group A, Auckland)

Navigating the boundary between a person's aspirations and service expectations, created considerable stress for participants in determining how they worked with the people to whom they believed they were ultimately accountable. For example, an Auckland support worker acknowledged, "my ideal for him may be totally different from what he has for himself" (Support Worker 3, Focus Group B, Auckland). But she was also aware that the service user would know, himself, when he was ready to move on to the next stage. In the end, what service users wanted for their lives came down to important distinctions between their own aspirations and service goals.

Aspirations versus goals

Autonomy or personal power clearly involved the rights of people, with lived experience of serious psychological distress, to be their own primary source of expertise and to have access to the resources, rights and opportunities that allowed them to make decisions about their own best interests. Many were keen to distance themselves from more conservative notions that emphasised functional independence and setting goals. Locating recovery in a more general discourse of well-being situated it within a broader field of health promotion, rather than the biomedical frame of illness and disease. This reinforced the sense of an aspirational "self" as opposed to merely one of maintaining

functionality and symptom control. This clearly increased hopefulness and “an excitement about what the future might bring for you” (Peer Support Worker 2, Focus Group S, Christchurch) as well as expanding people’s expectations of their horizons. A team leader from a service user led organisation referred to talking to people about their wildest dreams rather than their service needs.

Senior managers also spoke of people’s aspirations but, perhaps indicative of their more strategic vision, used vague and somewhat ambiguous terms that were not necessarily measurable. For example:

People want more work, better connection, better accommodation, more money and a sense of satisfaction and success in their life. So there are global things, but every person wants different bits of that.

(Senior Manager 4, Auckland)

Similarly, another articulated her concern that services were typically disability support services and rather than focussed on improvements “in their feeling of well-being and a feeling of being more in control of their life and their existence and their destiny” (Senior Manager 2, Christchurch). In contrast, the CEO of a service user organisation in Hamilton described their recovery service as supporting people to invest themselves in their life.

However, more frequently, the notion of independence diminished recovery to merely the setting of goals against which outcomes could be measured. These were invariably focussed towards service exit as the only outcome that really “counted” in terms of their funding and contracting requirements. Most importantly, however, it shifted the locus of power from a personal subject with sovereign rights of self-determination, to an objective service assessment of their capacity and readiness.

I think we also do [recovery] within our paperwork, you know working with a person on their goals and reviewing their service reviews. We also have support assessments, which are done every six months, you know [and] working towards

moving through the system.

(Team Leader 2, Focus Group P, Hamilton)

Participants frequently appeared to accept as natural the idea of setting goals as a way of defining a person's recovery journey and progress, while at the same time acknowledging these goal plans as obligatory service and contracting requirements. Some participants even referred to "*getting them* to do their goals" (Support Worker 3, Focus Group H, Hamilton) without any apparent sense of the contradiction between this coercive behaviour and their organisation's claims of being "client-centred". Some support workers and team leaders clearly felt conflicted when service users did not want to do goal plans, especially when it was clear that these put pressure and expectations on them. But as an organisational imperative, they routinely came up with other ways to complete them, such as negotiating with service users to complete them orally. It was never an option for service users not to participate in goal setting at all:

Goal planning or the recovery goals are like, you know in [organisation] policies they are fairly set out rigidly. Some people don't want to be participating in formal paperwork, so it is about being innovative and trying to find out what are the interests of this person, and then incorporating those interests [into the goal plan].

(Team Leader 1, Focus Group W, Waikato)

Many participants explicitly stated that goal planning was an organisational constraint that was often in tension with the aspirations of service users in terms of their ordinary living. For example, a team leader from Hamilton explained that conflict arose because, for clients, "recovery was around being the best person I could be here and now" where for the organisation it was about "moving on, outcomes focused and meeting key performance indicators you know" (Team Leaders 5, Focus Group A, Hamilton). This conflict was clearly a source of frustration for many, especially as goals were driven by organisational expectations and created considerable anxiety for service users. It

“scares the shit out of some of them” said one support worker from Wellington (Support Worker 2, Focus Group A, Wellington).

Of course, some of this goal planning was very successful and worthwhile and several organisations tried assiduously to be as flexible and responsive to people’s needs as their own contracting requirements would allow. Many tried hard to straddle dual expectations of service users and contracts, aiming to make goals meaningful and aspirational:

We are aiming for what the service user is aiming for and sometimes [we] talk about stay-goals and go-goals [. . .] So their go-goal might be about getting work, and their stay-goal might be about staying in their current relationships [but] developing them a bit further. So sometimes, it is . . . more about enriching the quality of what you are doing. [For others] it might be going, finding something new.

(Senior Manager 4, Auckland)

Similarly, very few service user led organisations mentioned recovery in terms of goal setting and where they did, the sense was of an unavoidable evil for meeting contracting requirements. Many spoke of having to work around mandatory form filling and goal plans that created arbitrary time-lines in order to “get their dreams away up there, we head towards that in a roundabout sort of way.” (Team Leader 1, Focus Group A, Hamilton).

Goal setting, however, was clearly and nominally, the quantifiable and measurable aspect of recovery for organisational contracting requirements, and it was a mechanism for accountability to funders and not a feature of recovery in itself. Many participants admitted that needs assessment and goal plans were purely administrative requirements and they might sit in a file for six months until review time. Other organisations were very active about goal plans, but this also meant that both support workers and service users were required to account for their time together solely in terms of progress towards identified goals, whatever new life circumstances might have arisen. In this context,

therefore, the only meaningful outcome for organisations was invariably service user “exit” from the service.

Living an ordinary life in community

The original *Blueprint* (Mental Health Commission, 1998) stated unequivocally that “recovery could never take place in an environment where people were isolated from their communities” (p. 1). Indeed, all participants acknowledged the importance of “community” in recovery although this was variously constructed. The distinctions corresponded to the different ontological constructions of recovery that either positioned people as returning to “normal” life from a place of deviance or as struggling to reorganise lives and relationships from the context of frequently catastrophic experiences. Emerging discourses of well-being also emphasised the responsibilities of communities for accommodating the vulnerabilities, and supporting the aspirations, of all members and emphasised the reclamation of the rights of citizenship as well as the healing power of community. A peer support worker from Auckland described the impact of alienation from community:

A lot of people feel isolated from the community because they have been cast out basically because of their diagnosis and not accepted, so they feel very disconnected from the community. All research shows that all human beings have innate need to feel part of a community.

(Peer Support Worker 2, Focus Group PS, Auckland)

Several ideas were important in participant discussions of “living in community”. First was the capacity to do the ordinary things that made up life for most people. Second, was having the opportunity to contribute to community life as well as having access to the resources that were implicit in the rights of citizenship. In addition, emerging discourses of recovery and well-being constructed communities as agents of health promotion, with a responsibility to promote acceptance and be communal in their support of the flourishing of all members. These notions contrasted with commonly used constructions of

community and community care that referred merely to physical locations and generally indicated other social services and DHB community mental health teams.

These were not simple binaries, however, but a complex set of contextual, shifting and dynamic factors. It was also apparent that constructions of community varied in both their implications and applications in mental health services. Positions and boundaries were often blurred in focus groups with participants slipping unconsciously from one construction to another. This was less the case in interviews with senior managers, whose articulated positions more consistently reflected their strategic policy goals and mission statements. Participants from organisations with strong service user focus or leadership also tended to have community connectedness at the forefront of their endeavours. At the end of the day, service users clearly centred their aspirations on their capacity to have an “ordinary” life.

Being ordinary and connecting with the community

Most participants acknowledged that, whatever their diagnosis or disability, people “still lived most of their life in the community” (Senior Manager 1, Hamilton). This meant that, more than just being tolerated, people needed a valued place in their communities of choice. Recovering community, from the perspective of participants with their own experiences of serious psychological distress echoed the expectations outlined in *Destination recovery*:

A valued place is reached when people are an integral part of safe, strong families, have equal access to education, employment, housing, transport, and goods and services, and are free to participate in the commercial, cultural, political, spiritual and recreational life of their communities. (MHAC, 2008, p. 29).

This construction highlighted the role of communities in creating disability; where exclusion was more a result of poor societal responses than a person’s pathology (Harter et al., 2006; Sayce, 2001). A senior manager from

Wellington articulated his organisation's vision for "fully integrated communities because that is the environment in which recovery can grow". He went on to add that this required communities to have "greater knowledge and ownership" of the experiences that had led to isolation and distress both before and after people had entered the mental health system, and to be resourced in "how to be with it" (Senior Manager 2, Wellington).

For many the benefits of being in community meant focussing on the ordinariness of life rather than services based on diagnosis or in reference to illness. For example, a team leader from Hamilton was concerned about the focus on people's lives being that of a "professional patient" and wanting to reverse that into "making that only a small part and the rest doing all the usual things. Eating chocolate and going for coffee, doing the dishes" (Team Leader 4, Focus Group H, Hamilton) Many participants spoke of the importance of doing ordinary things with service users; having coffee at a cafe, going to the beach, being a walking companion, or just being a witness to the journey of another's life.

However, there were obvious tensions between merely getting out and about, doing ordinary enjoyable activities as an individual person, and actually engaging and connecting with others in the natural settings and contexts of community life. In the most unreflective cases, being "out in the community" was restricted to going to the supermarket and learning to catch a bus. However, other participants used similar anecdotes to challenge them as examples of poor, non-recovery-oriented support work. Individualised activities, with support workers as companions, clearly had their place, but too often, there were no other strategies that facilitated engagement with groups or organisations outside mental health services.

Participants talked about what it meant for service users to be connected to the community; contributing to and feeling embraced by community life. Implicit in these conversations was the sense that facilitating, and maintaining, access to community resources and opportunities was central to creating an ordinary life and a preferred future, and was as much about strengthening

communities as it was about individual responsibilities to adhere to social mores. As this senior manager from Auckland argued, “Community participation is actually having [things], doing things which facilitate the feeling that you are a valued participant in your community” so that people are contributors, “actually part of the weaving of the community” not merely spectators with “other people weaving around you” (Senior Manager 4, Auckland).

As well as engagement with the ordinary activities of living, many participants emphasised the need for personal choices about “the life I want to live”, whether or not this looked normal to others. This could be a difficult boundary to navigate. While personal empowerment was central to most discourses of recovery so was the capacity to become a confident social being and a member of community. Several participants noted that people needed to learn to take care of, for example, their living environment and personal hygiene in order to be accepted by others. A team leader from Hamilton remarked, “Unfortunately we do need to get on with our neighbours if we want to have a fairly smooth, quiet life” as well as developing the skills “to negotiate relationships if people aren’t to become isolated” (Team Leader 1, Focus Group P, Hamilton).

The construction of community, as an environment rich with resources and opportunities, appeared indicative of the extent to which participants and organisations were integrating recovery discourses into their organisational communications and practices. For many, connecting people to their communities, whether old or new, was an organisational imperative for recovery and, as one senior manager from Auckland remarked, “it just seems to me to be a compelling thing to do” (Senior Manager 2, Auckland). This was also related to the theme of people rebuilding their self-confidence through new “adventures”.

Encouraging an adventurous life enabled workers and organisations to identify and draw on people’s strengths, interests and previous achievements to promote new opportunities that rebuilt self-esteem as people experienced achievement, realised what was possible and what they could accomplish in the “real” world. One senior manager explained that he liked the focus on strengths

because “everyone has had hobbies, sports and pastimes that they may want to reconnect with” and that a focus on future possibilities should have “one eye facing forward and one eye facing back” (Senior Manager 3, Auckland). Unfortunately, a sense of adventure was not only missing from clinical goal plans and outcome measures but frequently at odds with contracting requirements of *risk management* and *risk aversion*. A senior manager from Hamilton faced considerable resistance from clinical staff when he set up a rifle range for people who were in an inpatient ward at the time.

It was all done properly . . . we had guys come who were very low motivated, didn’t want to participate, and when they left they were buzzing, they were jumping up and down. And we started getting comments from the wards “What have you done to these guys? They are just so motivated, they are wanting to do things.” (Senior Manager 4, Hamilton)

Despite such efforts, being “in community” was seldom easy or straightforward for many service users, many having faced years of institutionalised control as well as on-going stigma and discrimination to varying degrees. Participants reported that many worried about fitting in and they were appreciative of the courage of service users, acknowledging that it was “scary stepping up to a whole new group of people and allow them to discover you and for you to discover them” (Team Leader 1, Focus Group P, Hamilton). Similarly, finding the entry points into the community was a real challenge for many service users:

Community is such a hard thing in this day and age, unless you are a member of the church or something, which is a really great type of community in terms of support for people. If you are just out there and housed by yourself and you don’t have family around, where do you get that sense of community, and so you have to work at it and actually search for it and find it and develop it yourself, and that can

be really hard.

(Peer Support Worker 5, Focus Group PS, Auckland)

Notions of *community care* were, also, very ambiguously constructed. The clinical construction tended to refer to the physical location of outpatient services as well as local community agencies. This tended to perpetuate a marginalised “community” of mental health service users at odds with recovery and ordinary living within a community with ordinary people.

The community that cared

Many participants seemed to refer to “the community” as the local range of community services and agencies including churches and charities that provided activities for people to occupy their time and meet others. While this was not necessarily problematic it frequently seemed couched in an old fashioned paternalistic benevolence that focussed more on “good people doing good things” in their community rather than the personal empowerment of service users. For example, a team leader from Waikato recounted, what she described as “a beautiful story” about “how some ladies from the Anglican church have taken this person under their wing, and included him in plays, and when they told me about that, what wonderful opportunities and how fabulous that is, and it is just lovely, lovely caring people” (Team Leader 4, Focus Group W, Waikato)

On the other hand, it was difficult to manage the boundary between supporting people to rebuild their confidence and aspirations without relegating them to a life of “filling in time” on the borders of communities. Some support workers saw their role as learning about “a lot of different organisations that are available” and then helping service users to access these so they “are not bored or wasting their days, or just you know getting them to that stage where there are going to be things in the community that they might really want to go and try” (Peer Support Worker 4, Focus Group S, Christchurch). In some cases participation proved to be yet another site of coercion and a support worker

from Wellington described the reaction of service users when she suggested a “community” programme:

If I mention [another service], it’s like a filthy dirty word. “I went there for 20 years”, or “for 10 years they forced me to go there, forced me otherwise they threatened I would be back in hospital.”

(Support Worker 7, Focus Group A, Wellington)

So saying, community participation did not seem to be valued by professionals, or considered in clinical plans beyond purely functional goals such as budgeting, cooking and house-cleaning. This meant that organisational and contracting constraints, which governed the behaviour of both service users and NGOs, frequently thwarted increased, active participation in community. There was evident conflict within organisations about regulatory control over who made the decisions about what was considered suitable activity. Team leaders in Hamilton discussed their frustrations at organisational policies that created barriers for ordinary community activities for adults, such as going the pub to play pool, to Auckland for the casino or even taking people out on weekends to the beach. As one commented:

We had to put in tons of paperwork just to get them up to Auckland, and we got the best parking deal at Skycity, and the best restaurant was up there because we got discounts, and by crikey, there are some red faces because we shouldn’t have gone near that place. But you know that's where people head to if they’re going [to Auckland].

(Team Leaders 1, Focus Group A, Hamilton)

Participants also reported tensions with service users being pressured to make continuous *measurable* change including going “to join the little centres and do cards or whatever, and that is only an hour or two a week” (Support Worker 4, Focus Group A, Wellington). Several support workers felt similarly coerced to “find something else for the next personal plan whereas where they are at now is actually really happy” (Support Worker 7, Focus Group A,

Wellington). They were frequently faced with explaining to service users that unless they were prepared to do *something* they would no longer have visits from their support worker. All of which amounted to very little personal power for people using mental health services.

Many participants opined that paid employment and living in a home of one's own, whether rented or not, represented belonging and participating in community. Work was clearly perceived as an important outcome, not only for a sense of contribution and involvement in the real, social world but for obvious benefits such as increased income. However, as one team leader added the real value was that, for service users, "their self-worth just really goes through the roof, they feel like socialising; everything about work just changes them completely" (Team Leader 1, Focus Group A, Hamilton).

Many organisations created, and encouraged, opportunities for service users to experience ordinary interactions and relationships within the general community through voluntary or paid work. In one small community, an organic garden was established and developed within the service. This not only provided a sought after service *to* the community in terms of valued food produce but was an important means for building people's confidence *with* the community. In this project, neither staff nor service user roles were static or fixed and people took on more responsibility and leadership as they felt capable. This meant people progressed upwards and many moved out of the service altogether. In one case, a team leader explained that a service user had "got a job as a result of being in the garden, and now he has left the whole service" (Team Leader 3, Focus Group W, Waikato).

Somewhat paradoxically, professionals were often responsible for holding service users back despite the emphasis on "exiting" people from services. Research participants described many professionals as routinely pessimistic, and they used notions of "risk aversion" and "work readiness" to justify further control over people's lives. A senior manager from Christchurch described how counterproductive it was when occupational therapists and other professionals wanted service users "to do a very slow transition process to work" when there

was compelling evidence that “finding work and supporting people to manage the kind of issues in their life to get [work], and keep it, is what works for people” (Senior Manager 2, Christchurch). Most importantly, this reluctance further eroded service users’ confidence that they could ever truly regain valued roles in the community.

Having one’s own home, rather than living in enforced group sharing arrangements in supported accommodation was also hugely significant and empowering. This offered personal freedom from service intervention as well as the power to insist that “in my own place I don’t want you guys around 24 hours a day” (Support Worker 2, Focus Group W, Waikato). But participants reported that, far from facilitating personal power and choice, services, particularly clinical services, often stood in the way of service users reengaging with community on their own terms. This was not merely ineffectual but frequently led to negative outcomes. A team leader from Hamilton expressed his frustration at the revolving door syndrome when service users’ own recovery aspirations and desires were not met. In one case, a person was continually sent to live “independently” in the community; but on his own and against his clearly expressed desire. As the team leader explained, whatever other people thought was appropriate it was as “simple as that, he wanted company. He’s now happy living in a room down at the Commercial Hotel. (Team Leaders 2, Focus Group P, Hamilton)

Other participants noted that “not everyone is built the same” and it was important for people to define for themselves their natural state of sociability. One participant described her own personality as a “bit of a loner” adding that she was “quite happy with my own company, I don’t have to go out and join a whole heap of groups” (Support Worker 3, Focus Group P, Hamilton), and yet social connection was often mandated for services users and could easily become paternalistic or prescriptive based on staff or service values.

Overall, there was considerable ambiguity around the constructions of community and community care, despite national policy and strategy documents stating that community participation was a desired outcome. Many participants

and organisations were still heavily constrained by their contracts in how this was enacted in practice. This not only narrowed the boundaries of community for organisations but also impacted the degree of personal power and choice available to service users trying to reclaim a meaningful and valued life as a rightful citizen in the community of their choice.

Organising recovery: Relationships, roles & outcomes

The previous sections concerned participant constructions of madness, journeys of recovery, and what constituted an ordinary life in community. These constructions then provided the context for the ways that participants and significant texts constructed recovery-oriented mental health services and the community NGOs in particular. Participants were asked what was working well in their organisations in terms of recovery, what was constraining their best intentions, and what they envisaged were the best possible outcomes for users of their services. From these discussions it was evident that participants considered as a given that their organisations were recovery-oriented. However, the various groups constructed the meaning of this very differently, especially those who were from either peer support teams or service user organisations. This was also despite the fact that most described their organisational communications and practices as influenced more strongly by contracting and funding requirements than genuine empowerment and choice for service users.

In this section, I focus on four major aspects of the organisation of recovery as discussed by participants. These are the anticipated outcomes of recovery-oriented organisations; organisational identity and niche; organisational relationships and communication, both internal and external; the perceived roles of participants and their organisations within mental health services.

Recovery: The nature of outcomes

The Mental Health Advocacy Coalition (2008) has stated that “measures of effectiveness of services (should be) simple and focus on outcomes that are important to service users” (p. 10). A senior manager from Auckland described

his organisation's perspective on positive, recovery outcomes as assisting "someone to better their circumstances or improve their life in a way that they feel meaningful" at the same time acknowledging that this might mean "different things to different people". Good individual outcomes, therefore, might range from someone getting a job to recognising when "the voices are getting just a bit too loud" and "they are not able to manage that anymore". However, it might also be that a person "actually cooked something for the first time in their lives", or "talked to their Mum for the first time in 20 years after burning those bridges" (Senior Manager 2, Auckland). But it was evident from participant talk that these, more subjective, senses of progress and outcomes were not considered adequate measures by DHB funders in most regions.

As discussed earlier, workers with lived experience of serious psychological distress talked about the fundamental goal of recovery being *transformation*; beginning with the opportunities, personal power and support to find meaning in their experience and to integrate it into a new and transformative identity. In contrast, the perception of many research participants was that funder expectations drove their organisations and recovery outcomes were purely functional with service exit the only outcome that really counted. Therefore, organisational record keeping and reporting focussed on linear progress and expectations of discharge. These measurements of recovery progress were a source of frustration for participants as well as service users. As one participant from a service user organisation protested, "Is it a measurement of success, seeing someone for an appointment once a week, three months, six months?" (Senior Manager 2, Hamilton)

Senior manager participants described instances where, despite excellent evaluations, community non-government services were either cut or put on three-month contract rollovers by their DHB. These events exacerbated concerns that narrowly defined recovery outcomes, such as the increasing pressure to adopt the clinical assessment tool HONOS worked against the personal outcomes and unique achievements of ordinary living. Participants challenged the extent to which positive changes in life circumstances or

individual growth could be measured objectively, and whether these were even attributable to mental health service intervention or involvement, given that they neither considered nor controlled for situational factors. For example, a CEO from Auckland commented that measuring outcomes tells only one of many possible stories, and that these typically meet service needs rather than personal aspirations. He commented:

I suspect if you ask people they will tell you what is a good outcome for them, and maybe it is not as measurable as we think it is. [Measuring outcomes] tells us more about what [the organisation is] doing [rather] than what service users think. (Senior Manager 2, Auckland)

Objective or statistical measures of progress, therefore, were an uneasy fit with more subjective and personal senses of achievement. This was compounded because clinical teams were primarily concerned with symptom reduction and behavioural control that narrowly proscribed recovery. One participant described this position as, “Well if we manage your symptoms with medication then that is the level of recovery that can be expected” (Team Leader 4, Focus Group A, Christchurch). This was problematic for both support workers and service users, not only because medication and side-effects were often perceived as detrimental to personal choice and recovery. Of more concern was that, “Where services are concerned we are still in that phase of outcomes and you know tick the boxes and where they fit: and they are *their* measuring sticks and not the individuals” (Team Leader 4, Focus Group A, Christchurch). Participants reported considerable difficulty negotiating these other expectations with their own constructions of recovery and support centred on individual choice and aspiration, with one saying, “If we run a recovery-oriented service we have to be careful not to make it our recovery” (Team Leader 4, Focus Group A, Hamilton).

This created an important discursive and, ultimately, epistemological issue for organisations faced was with requirements for objective measures and performance indicators that conflicted with the narratives or stories that many

believed were more meaningful. Many participants commented that even though they were now encouraged to provide narrative reporting, this was an adjunct to the statistical information that formed the core of reporting expectations, and it was unclear whether these were even read let alone utilised in policy decision making. In the end, it became just another administrative chore for many. The CEO of a service user organisation in Christchurch described the narrative reports about organisational activities and outcomes she produced for the Ministry of Health as her “effort to feed a picture”. However, she went on to note that she commented to the Deputy Minister of Health that, “I don’t know where they go when I leave them, I have no idea if anyone reads that narrative” and he apparently replied that he did not either but he would find out. However, she reported that she never heard back. (Senior Manager 1, Christchurch)

The narrative accounts of successful recovery, often posted as good news stories on organisational websites or in texts such as *Frontline* (Peters, 2010) and *Destination recovery* (MHAC, 2008), were also open to interpretation and translations that were not truly reflective of organisational endeavours to “realise their best intentions” with respect to recovery. As a senior manager from Auckland remarked, “Success stories aren’t outcomes; they are wonderful stories of an individual outcome. They are not outcomes for an organisation point of view” (Senior Manager 3, Auckland). On the other hand, several participants expressed disappointment that when their organisations published service user stories of madness and recovery these were typically used as examples of successful service outcomes rather than genuine attempts to shift the construction of mental illness itself. This was related to a phenomenon that several participants referred to as “posters on the wall” which hinted at their disillusionment with surface, and ultimately discursive, rather than substantive changes in paradigm and practice.

Participants generally agreed that recovery meant people living a life of choice in their ordinary communities and no longer requiring service support. However, several tensions arose with how *exiting* services was constructed. At

the heart of the conflict were contracting specifications and funder expectations of unilateral, linear movement towards discharge that most participants believed exerted undue pressure on both them and service users, and were antithetical to recovery principles of personal power and choice. Several participants commented that their observations of service discharge were, “pretty much that they are forced out” despite service users being “not quite ready to go yet” (Support Worker 4, Focus Group A, Christchurch).

This construction of service exit, as an outcome, contrasted with what many participants described as service users “getting on with life” (Team Leader 2, Focus Group W, Waikato) or becoming “too busy to see me” (Team Leader 1, Focus Group P, Auckland). The distinction between “discharge” and just “moving on” with life depended on where the locus of power was situated. In other words, who or what was driving and determining the pace of a person’s journey of recovery. The CEO of a service user organisation in Hamilton described this as people getting “a real life again” and feeling “wanted, loved, respected [and] a worthwhile and integrated part of society” (Senior Manager 4, Hamilton).

Participants agreed that “best practice” support work relationships should be time-limited, temporary and focussed on a person leaving the service because they were ready, willing and able to take up a full life in their community again. This approach expressed a hopefulness about the future, that “this too shall pass”, which was clearly missing in clinical and other services. However, participants were clear that this needed to be in the best interests of the service user rather than the requirements of organisational structures and processes. Being recovery-oriented for participants meant increasing the flexibility and responsiveness of services to the fluctuating needs of service users. A senior manager from Auckland said that to be truly recovery-oriented you needed to expect recovery and this meant consistently pulling back. He added that this meant sometimes “pulling back at a very slow rate, other times you are pulling back very quickly” (Senior Manager 3, Auckland)

However, there was also a concern about service exit as “abandonment” and several participants reported that this created considerable anxiety for

service users. In practice, the processes of clinical assessment meant people were not able to get help when they needed it and they feared discharge would mean being shut out from relationships and services they knew and trusted. Having to go back to the beginning and re-enter the system through a clinical assessment, with all the associated trauma that entailed was fraught for many. Several organisations endeavoured to get around their contracts in this regard, offering service users phone-call support, or reassurance about re-entry to the service, if required; but they typically had to juggle and re-allocate resources to do so.

Many participants reported attempting to negotiate conflicting expectations in a variety of ways. One important strategy was to attempt to increase the “meaningfulness of goals” (Senior Manager 4, Auckland) rather than apply a simplistic measurement of progress against pre-set targets. In three organisations, this was formally incorporated through the development of matrix frameworks that endeavoured to capture life dimensions that were relevant, important and personal for service users without enforcing a prescriptive one-size-fits-all set of processes. In addition, several organisations actively sought to be pre-emptive with respect to contracting and service specification changes; developing organisational measures and processes that met their own organisational values and objectives before more restrictive requirements could be imposed.

Meaningful employment and paid work were mentioned frequently as organisational measures of success for service users. However, there was ambivalence about how low expectations and stigma were expressed in the notion that “any old job will do” or being in a job, merely to “tick the [outcome] box” (Team Leader 2, Focus Group P, Hamilton) rather than desirable and meaningful employment. This clearly impacted negatively on service users’ self-confidence and motivation, becoming a self-fulfilling prophecy for many. In one Wellington focus group discussion, a team leader explained how low expectations sent a message to service users, “You can’t expect to do any better. We don’t expect you to be able to achieve anything better than a cleaning job

despite what you have done before; your knowledge and experience” (Team Leader 2, Focus Group A, Wellington). Another participant from Hamilton concluded that the measure should be “whether that's added value to their life or whether it is just one of the things they have to do to get an outcome, and is probably what the majority of society out there [expects]” (Team Leader 4, Focus Group A, Hamilton).

Another outcome reported as particularly important to service users was “having a place of their own”, whether this meant living alone or with others. Living in residential services with others not of one’s own choosing was reported as unsatisfactory for a variety of reasons. Sometimes it was about the anti-social aspects of their symptoms such as hearing voices or being “paranoid about what your neighbour is thinking about you” which meant that “sleeping in the same house as someone else is just impossible” (Team Leader 6, Focus Group A, Hamilton). However, for most it was just because, “they’ve got their own stuff around them, they can personalise it to the way that they want to which then brings up a sense of pride in [their] environment. [They] want to invite people in for a coffee” (Team Leader 6, Focus Group A, Hamilton).

Others reported, however, that many service users liked sharing a home with others, and this could create issues for services, who were expected to move people on and out. Several commented on the irony of moving people out, with the anxiety and sense of abandonment this could create, just as they had become secure and happy in their sense of being in the world. One Auckland organisation negotiated this dilemma innovatively and effectively by moving the service itself out and leaving the people behind to get on with their lives. As the manager of this service commented, “We buggered off. And that worked really well. [They] are still getting the support they require. We have just gone, letting them get on with it” (Senior Manager 4, Auckland).

Most organisations and participants, therefore, were determined to work around the expectations and constraints of the contracting and funding environment in terms of achieving meaningful outcomes and being recovery oriented. But this was clearly an on-going struggle with more powerful clinical

services. In the next sections, I examine how participants constructed a recovery orientation in services and what this implied for establishing a unique, valued identity and niche within the gamut of Aotearoa\New Zealand mental health services.

Becoming recovery-oriented: Organisational identity and niche

Community NGOs in Aotearoa\New Zealand have typically been responsive to the values and principles of a recovery model despite the obvious difficulties (Harrison, 2010; McMorland et al., 2008; Peters, 2010; *Platform Trust*, 2007, 2008). Most participants in this research claimed their organisations were recovery-oriented, in line with the values and missions mandated by their trust deeds and constitutions. Yet these organisations, and the support workers specifically, were inevitably positioned and *identified* as less knowledgeable and less credible than their clinical counterparts within the spectrum of mental health services.

For many participants being recovery oriented meant being innovative wherever possible and it was in this area of participant talk that endeavours to undertake organisational transformation were most apparent. Among the initiatives discussed were KeyWe Way, a peer respite service in Wellington (*see also* Peters, 2009) and the intentional peer support teams established in some organisations and funded under distinct contracting arrangements (*see also Central Potential*, 2008; Mead, 2005; Mead et al., 2001; Ley, Roberts, & Willis, 2010). There were also a variety of local and organisational initiatives that encouraged healthy, active lifestyles, as well as organic gardening, book clubs, coffee groups, music, comedy and radio ventures that were generally coordinated by peer support teams or service user led organisations. Various efforts to increase the credibility of community NGOs were also apparent. These were mostly sited in Auckland and included attempts at collaboration by bringing clinical staff on board as well as developing sites where clinical and community services were located side by side (*see also* McMorland et al., 2008; Peters, 2009).

Strongly articulated values embedded throughout organisational leadership and communication practices were the best indicator of a recovery orientation. This became evident, almost incidentally, through the inclusion of participants from all tiers of five organisations, two of which were national. In addition, three other support worker and team leader focus groups were representative of a single, or two allied, organisations. This enabled close comparison among the cohorts of a particular organisation. Two organisations provided the best evidence that organisational leadership, and/or the presence of strong service user participation in the development of policy and practices, reinforced a recovery orientation in an organisation.

One of these organisations, in Wellington, had a history of active service user participation in the senior management team, one of whom commented, “We have lots of recovery conversations, I mean it, we have lots and lots conversations with service users and team members and the wider organisation” (Senior Manager 2, Wellington). The other, in Auckland, had established peer support teams within the organisation, and a service coordinator remarked, “More and more it does feel like a values centred organisation. I know that often we are focused on what needs to change, especially in my team because we have got a quality focus” (Senior Manager 1, Auckland). A peer support worker supported this claim when he remarked that he “loved the fact” that the organisation was “moving away from sick, [and], focusing on living, that is a huge one” (Peer Support Worker 6, Focus Group PS, Auckland). The communicative practices in these organisations emphasised systematic reflexive practice, including a weekly “listening post” where staff and service users could talk to the CEO about anything they chose uninterrupted. Another senior manager from Auckland described the congruence within his organisation as “strong social justice values that have been developed and massaged for 100 years [that] is very useful, we have a very strong philosophical foundation” (Senior Manager 3, Auckland).

Unsurprisingly, authentic recovery orientation was also evident in comments from participants who worked in service user led organisations. One

senior manager from a service user organisation in Hamilton commented, “A recovery service is about investing yourself in your life” (Senior Manager 4, Hamilton). Most participants remarked on the importance of service user involvement in service development, and not only through the establishment of peer support services. For instance, an organisation in Auckland was actively “increasing service user involvement in service development and planning processes” and putting “a lot of effort and resource into building the capacity within service users to do that” (Senior Manager 1, Auckland).

However, other participants spoke of their frustration that recovery and strengths-based practice had become little more than “just changing pamphlets on the wall” (Team Leader 3, Focus Group A, Hamilton). For example, another support worker from a different focus group in Hamilton remarked that her organisation had,

something up on the wall that talks about strengths based things [but] they only focus on the strengths when they want to discharge someone, and they want to tick the little ticky boxes that mean that they’ve achieved their outcomes. I haven’t seen that much in practice in terms of the work that is done for people.

(Support Worker 2, Focus Group A, Hamilton)

This reinforced the sense that establishing an authentic recovery orientation within the mental health services environment was clearly a struggle for many organisations.

Focus group questions also unearthed how participants envisaged the identity of, and niche for, community NGOs as credible organisations within the sector environment and as champions of recovery. Most of the discussions reinforced strong advocacy and leadership as being crucial aspects in rebuilding the confidence people had lost to discriminate between what was normal life, and what was “illness”, due to the pathologising of their feelings and experiences. Therefore, central to the talk about organisational identity and transformation was a desire to open spaces for challenge and adventure that

would provide on-going opportunities for growth and success. This frequently meant developing creative, innovative strategies and adopting a “do whatever it takes” approach to service delivery. And organisations often went beyond the bounds of their service contracts, as the CEO of a Kaupapa Māori organisation explained:

We have a [contract], which is funded for two education workshops per year, and we do four a week. [We] can't afford it but [we do it because] the community wants it. [They] haven't got any money, but there is a need over there and we have expertise so

(Senior Manager 2, Hamilton)

He went on to explain that, “It is not about qualification[s]. It is [about] innovation; it is being willing to step outside of the framework.” Other participants echoed this sentiment and it seemed that organisational approaches based on social, rather than medical, models consistently meant having to break the rules. As one team leader explained:

[I was told] “Don't ever pick anyone up for accommodation [issues]” and that was by a [DHB social worker]. Well I pick everyone up; that is the first thing. Most people come through the door with accommodation issues, [and] that is the issue beneath the whole iceberg of stuff. [So] if you just have this strict rule [you] miss working with people who have actually got huge life stresses going on [and] it all ties in together. (Team Leader 5, Focus Group A, Hamilton)

The capacity to work with people in flexible, consciously purposeful ways required the strategic management of contracts, funder expectations and service specifications. But this clearly drained the resources, effort and energy of the organisations. One senior manager explained that her organisation was constantly having to “twist ourselves into knots to meet a service spec and then spend half our time trying to rewrite that, and you know kind of fudge it in a way

to meet the requirements". However, she added, "we are actually doing what we know people want and what works" (Senior Manager 1, Auckland).

In general, participants saw the niche for the sector in people feeling that services "are part of their support network. [We] are not all of it; we are just a chunk of it" (Senior Manager 1, Auckland). Implicit in these discussions was the notion that successful recovery and re-engagement with community were fostered more by qualitative and circumstantial factors. These aspects included the nature of relationships people had with organisations, the encouragement they received to be adventurous as well as service responses to difficult and challenging experiences.

Recovery: Relationships and roles in service delivery

The nature of support relationships and participants' perception of their roles was integral to all discussions of recovery. Most participants were aware that the *human-to-human* encounter was the most important aspect of their role, and that, in and of itself, could be therapeutic. It was the ordinary activities, conversations, mutual relationships and just catching up that was important. As this senior manager of a service user organisation in Hamilton expressed it, "We talk about life, and can often spend up to half a meeting just talking; catching up with where people are at and what they've done; what they've been through within the last week, two weeks, or when they last came" (Senior Manager 4, Hamilton)

Roles and relationships that supported recovery appeared to involve assisting people to widen their repertoire of strategies, capacities, resourcefulness and self-awareness in order to move on with their lives. This meant organisations and support workers needing to be supportive of each stage without pressure or expectations. Some participants even explicitly stated that "[We should be] investing in relationships not beds" (Senior Manager 3, Wellington).

Support workers, as well as workers with lived experience of serious psychological distress, spoke frequently of the value of just "being with"

someone, of witnessing their journey and of demonstrating care, optimism and belief without being directive. Several participants talked about the evidence of success being frequently intangible; witnessing a person's capacity to "enjoy rather than endure life" (Peer Support Worker 8, Focus Group PS, Auckland) or even building personal resilience by learning to "live *with* [their] mental illness rather than getting over it" (Team Leader 3, Focus Group A, Wellington). As one Wellington support worker declared, "Everybody on this earth deserves to have someone they trust knock on their door, or see them, or witness. They love that feeling that there is somebody that likes them" (Support Worker 2, Focus Group A, Wellington).

However, rigid time limitations and resource allocations were discussed frequently as being the biggest barrier to establishing effective recovery relationships. Participants, other than peer support workers, were finding it increasingly difficult to justify the benefit of just *being with* someone, "having a chat", when contracting requirements were so tightly pinned down to the achievement of pre-set goals. A support worker expressed his frustration as "I don't think you can measure the meaning of life" (Support Worker 4, Focus Group A, Wellington) and another complained of being "so answerable to everybody- what percentage of [a service user's] day was spent doing this or this or this, how are you showing it, what are the outcomes" and, she added, "it doesn't work like that" (Team Leader 2, Focus Group P, Hamilton).

The constraints of service specifications provided little time for ordinary conversations about people's lives, aspirations and significant experiences. Invitations to talk about what it was like for them when they went "mad" were either incidental or actively discouraged. "We're not counsellors" as one support worker in Wellington put it. Understandably, some support workers may have felt out of their depth in dealing with the frequently distressing nature of these stories. But this was clearly the basis of an effective relationship for many other participants. A team leader from Hamilton believed that the best support she could offer was "giving people time and listening to their story" because the people she worked with "have the most amazing stories and they don't often get

the opportunity to talk about them, and to talk about who they are (Team Leader 5, Focus Group A, Hamilton).

It was evident that a sense of reciprocity, mutuality and genuine regard was critical for effective and authentic support relationships; although this could also be a site of tension with notions of “professionalism” and professional boundaries. A senior manager from Hamilton believed in the importance of spending quality time with people. She said,

Don't always look for outcomes when you are meeting with them; get to know them, let them get to know you. Okay you have to create some sense of boundaries, but be open to sharing some sense of intimacy [because then] you actually move into a place of therapeutic practice [and the] person can honestly know who you are.

(Senior Manager 2, Hamilton)

Participants who also had lived experience of serious psychological distress described effective support relationships as encouraging a recovery process through the affirmation and identification of their strengths, resourcefulness and capacities as well as a “relentless optimism” about the future (Team Leader 2, Focus Group A, Christchurch). Several commented that an attitude of hopefulness often made the difference and meant reframing “failure” and recognising mistakes as learning opportunities. Many participants referred to the need to “believe in people, even when they had lost belief in themselves” and this included acknowledging a person’s own expertise was “just as valuable and important as the skills that a nurse has, as the OT [occupational therapist] has, as the doctor has.” (Support Worker 2, Focus Group P, Hamilton).

Recovery relationships were frequently articulated as “walking alongside” someone. While in some instances this seemed to be an unthoughtful reproduction of a cliché, it nevertheless represented a notion of partnership and even companionship which accepted that people could, and were, leading their own recovery with service involvement being only part of that journey. In several instances participants expanded on this metaphor in a variety of ways.

For example, “People do recovery whether they are in a service or not and if you really want to help someone you may as well help with what they are doing anyway” said a team leader from Hamilton (Team Leader 2, Focus Group A, Hamilton).

In contrast, several participants explicitly rejected the apparent complacency and passivity of a notion of *walking* alongside and reframed this as *working* alongside, implying an obligation to be an active and engaged companion in a recovery journey. At one end of this spectrum were support workers who “would use recovery as an excuse not to do the work with clients” and just say to someone, “This is what you need to do for your recovery: Now go and do it” (Team Leader 5, Focus Group W, Waikato). While at the other were support workers “getting involved, [getting] right in there” (Senior Manager 2, Hamilton). At the heart of the issue appeared to be the nature of an authentic support relationship and how workers and organisations could “act faithfully in someone’s best interests” (Senior Manager 2, Auckland). Several participants talked about “being real” and sometimes this seemed counter intuitive. For example:

We don’t believe in bending over backwards. And service users often find that difficult but then [they] start to appreciate it, because they are actually treated the same as everyone else in the population is treated. They are not special, they are not different; they are the same. Common garden normal and that is how we really work.

(Senior Manager 3, Auckland)

However, it was also evident that a basis of deep caring underpinned this kind of authenticity and honesty in these relationships. A support worker from Hamilton explained that respect and caring meant she needed to be able have the “hard conversations” and to say, “Hey the choice that you have made there is not great, why did you do it?” (Support Worker 1, Focus Group C, Hamilton). This idea was accompanied by the need for a kind of radical acceptance of a person’s circumstances, and as a senior manager from Wellington said, “People

are not out to create havoc for themselves, to make your life difficult” (Senior Manager 2, Wellington). This translated into a construction of a support role as a kind of tough love. A senior manager from Auckland described his approach as getting,

. . . very frustrated with this back to front nonsense. People say, “You have got to dress nicely and shower and look good before I will take you to a job interview.” Don’t be stupid, I wouldn’t do it. You go to the job interview, the person says, “Mate you look good but you stink, and I am not giving you a job because of that.” (Senior Manager 3, Auckland).

Unfortunately, and historically, service users have typically been framed as helpless and disabled, while support workers have usually been attributed roles as home help and caregivers. This has created systemic, institutionalised relationships of co-dependency that have been difficult to break down. A senior manager from Auckland explained that it was like any ordinary professional relationship:

You go to see your accountant because you have accounting problems, you then don’t keep on seeing your accountant for five [years]. You see a doctor when you need to, you don’t start visiting your doctor all the time. It is hard, but support becomes addictive. You start turning up and cleaning my house and never stop [then it becomes] “Good on you, you missed a bit.” (Senior Manager 3, Auckland)

Generally, an effective support relationship depended on who was in the driver’s seat. Many participants commented that service users were distrustful of professional relationships and particularly those based on the pathology of people’s experience, which ascribed the locus of power in professionals to make expert decisions, to guide, direct and “fix” problems. Participants were aware of asymmetrical assumptions of power and a team leader from Hamilton described a typical reaction to claims of expertise, “Oh I did this and this and this and I’m the [big expert]. They know that it’s a crock”. He went on to comment:

They're not going to tell you their story, they're not going to tell you their dreams and aspirations or whatever if they can't see that you are a real person. Otherwise you're a psychiatrist, someone who sits behind a desk.

(Team Leader 2, Focus Group A, Hamilton)

It was equally significant whether participants talked about either “asking” or “telling” service users. This was most apparent when talk slipped into a focus on deficits or “weaknesses” and led to remarks such as “getting them to [do] their goals” (Team Leader 5, Focus Group P, Hamilton) or “fixing their problems” (Support Worker 4, Focus Group B, Auckland). This contrasted with other participants who acknowledged that “everybody struggles” (Peer Support Worker 7, Focus Group PS, Auckland) with the issues of living at times. This called for a very different but simple approach that began with “the biggest question is to start asking, ‘What can we do for you to help you?’ That's a basic question I know, but most of them [just] get told what to do” (Team Leader 2, Focus Group A, Hamilton).

Realistic expressions of respect in mutual relationships functioned as a kind of modelling and helped people recognise their own power. A support worker from Hamilton commented that many people who had been in mental health services for years have found it difficult to form good relations and “they have been isolated [so] even just participating in a normal relationship is a great outcome” (Support Worker 2, Focus Group A, Christchurch). Others emphasised affirming and validating the essential humanity of serious psychological distress with one team leader declaring:

Recovery is giving them back everything that has been taken away from them you know; their self-worth, their independence, [and] helping them to go and find that, and doing the journey with them. Not just expecting them to travel along there by themselves.

(Team Leader 3, Focus Group A, Hamilton)

While participants and the NGOs were endeavouring to work as flexibly as possible, within contracting constraints, this was often clearly uncomfortable for clinical staff who were used to being in control of all aspects of encounters with service users. A support worker from Auckland told a story about supporting a young client to meet with his clinical key worker at Burger King. She explained, “because that was the place he was the most comfortable. [But] his key worker was this health fanatic, and she wasn’t comfortable there at all. [It] actually gave him more power than the rest of us because it was his environment” (Support Worker 4, Focus Group B, Auckland).

For most participants, the support worker role involved encouraging people’s capacity for developing a repertoire of responses for managing the vicissitudes of life; recognising, as one participant put it, “It is the strengths and resilience within the person themselves that is going to be able to lead that recovery” (Team Leader 1, Focus Group A, Wellington). This meant that a significant aspect of the role was modelling the ordinariness of life’s ups and downs; helping people to re-learn themselves; to identify their unique patterns, strengths and resourcefulness; to increase their personal confidence in being able to manage and judge for themselves what is normal and human. This required considerable courage and one peer support worker described “moving from a focus on sickness to a focus on living”, and making life better after “dealing with some tough stuff” (Peer Support Worker 6, Focus Group PS, Auckland). At the end of the day a team leader from the Waikato argued:

They don’t [actually] need us. They have survived. [They] are survivors most of them. And what they need from us is some alternatives, some skills, some ideas, some hope, but they don’t need us to tell them what to do, and I think that is the biggest trap you know.

(Team Leader 3, Focus Group W, Waikato)

Support workers and other participants framed their role very differently from DHB clinical services and funders who appeared to think they were caregivers or home help; if they knew or considered what they did at all. There

was a lot of frustration at this seemingly wilful ignorance on the part of DHB clinical teams. As a Wellington support worker described her situation, “If we say we are support workers [it creates] a kind of relationship with us by the clinical teams, ‘Oh what you do is cleaning and cooking’.” (Support Worker 2, Focus Group A, Wellington). One Team Leader from Waikato protested that being a support worker is “an incredibly skilled job and I really don’t think it is recognised” (Team Leader 4, Focus Group W, Waikato). Other participants resented being treated as hired help by clinical workers. For instance, “Some key workers think they are in charge and ‘You are my puppy and run after me’, or, ‘Can you go over and pick up their medication and take it over because I am too busy’, and I am like ‘Yeah so am I’. [If] it is not part of my referral I am not going to go and do that” (Support Worker 2, Focus Group H, Hamilton).

Breaking down these barriers was very difficult for most of these community workers and was very dependent on the attitudes of clinical staff and their interpersonal relationships. A peer support worker from Auckland explained that distributing information about the peer support service came down to the whim of clinical staff. She remarked that, “I have tried time and time again to be able to present our service to all the clinical staff because I think it is really important [and] they are just non-responsive really” (Peer Support Worker 2, Focus Group PS, Auckland).

National policy expectations are that people with lived experience of serious psychological distress should “experience trustworthy agencies that work across boundaries and enable service users to lead their own recovery” (Ministry of Health, 2005, p. 4). Yet, clinical goal setting and discharge plans were frequently produced with no consultation with service users, families or the community organisations who were written in to their implementation. As well as the process being antithetical to a recovery orientation in services, these plans were frequently different from service users’ own aspirations and desires, imposing constraints and expectations on both them and NGOs. Meeting expectations then created “a very difficult balance” for maintaining an

organisation's positive relationship and "not destroy[ing] it by the constant nagging" (Support Worker 1, Focus Group A, Wellington).

Participants in focus groups and interviews invariably characterised the relationships between clinical teams and the NGOs as hierarchical. They made frequent comments about clinical teams such as, "Even when the high up people are all for us sometimes it doesn't translate down to the people doing it" (Peer Support Worker 5, Focus Group PS, Auckland). Some senior managers, perhaps because of their more strategic focus, opined that future trends may increase the profile of the NGOs, but this was more likely to be driven by resource management rather than paradigmatic shifts. Nevertheless, some believed that resource constraints could be utilised as an opportunity to establish a niche for the community organisations. One senior manager in Auckland optimistically believed that, "Clinical teams [will] need to rely more on their community NGO partners, and I think there are things that [we] can actually do more [effectively] with benefit to the client" (Senior Manager 1, Auckland).

There were a few examples where participants believed their relationships with funding and clinical teams were working well. This had invariably involved a great deal of energy and effort on the part of the NGOs; but where this had worked the outcomes were, inevitably, considered worth it. For example, another senior manager from Auckland believed that collaboration with the clinical team had meant people moved more smoothly through the service and "they are getting their needs met in a more timely fashion, and there is a sense that things are more generally person centred" (Senior Manager 4, Auckland). In addition, there was evidence that alternative service specifications and contracting arrangements were available to a few organisations. This was particularly the case with service user organisations, others who employed designated peer support workers, and one Auckland organisation who had a contracted peer support service team.

Intentional Peer Support

Intentional peer support seemed to be the most significant initiative that contributed towards implementing a recovery orientation in the community organisations. These contracting arrangements, where they existed, provided comparative autonomy and were clearly extremely successful. They certainly offered greater flexibility and responsiveness, but the experience of the KeyWe Way peer respite service, which was put on three month contract rollover despite excellent evaluations (Peters, 2009), cautioned against planning ahead with any certainty.

Peers support workers had a well-defined niche within their organisations and the peer relationship was explicitly founded on facilitating personal power and self-determination. A peer support worker from a dedicated team in Auckland explained the key difference in peer support relationships was equality. She said, “We are not the experts in their recovery, and we know that they have inside them the knowledge of what is going to be best for them” (Peer Support Worker 1, Focus Group PS, Auckland). These relationships were clearly much easier to establish within peer support contracts that allowed them to both responsive and accountable to the service users they worked with; rather than being restricted by rigid contracting specifications. A team leader from Hamilton explained that their peer support workers offered “a huge difference in the way we practice compared to other staff”. She contended that enabling somebody to “speak is the best thing you can do for them, you know to be actually heard, really, really heard” (Team Leader 4, Focus Group A, Hamilton).

Peer Support workers clearly anticipated such conversations and they reported considerable anxiety on the part of service users that if clinical or “other” mental health workers knew what was going on an inexorable clinical machine would be set in motion that was not safe for them. They reported that service users worried that other workers would “run off and ring the CAT team” (Peer Support Worker 1, Focus Group PS, Auckland); that their experience would be framed in clinical terms and they would lose control of their lives. However, this meant that the peer relationship also carried with it some serious

responsibilities because people “have all told me that these are things that they have never told anybody in their lives you know. It is such a privileged and scary position to be in” and “by opening up to you they are giving you the choice to help them see that they can do things about this (Peer Support Worker 5, Focus Group PS, Auckland).

The overarching impression, emerging from the focus group and interview conversations, was how people used the same vocabularies, especially around notions of recovery, but clearly meant different things. It was apparent that, not only did participants use language in multiple, ambiguous ways, but that these usages were not of equal power.

Lost in translation: Conflicts and tensions

Recovery was inevitably positioned as the antithesis of the biomedical model in the literature as well as participant talk. However, despite an assumption of common ground, recovery was clearly being translated in ways that served particular interests (Maguire & Hardy, 2009; Venuti, 2004). It was also apparent that the emphasis on recovery in national strategy and policy was changing and becoming more fragmented (O’Hagan, 2009; Warriner, 2010). This suggested that new stories of recovery were being constructed and that these displayed multiple authors (Boje, 2001).

Many participants appeared to be aware that something had been lost from the concept of recovery and there were sites of ambiguity, tension and resistance. One support worker in Hamilton referred to “the big stick of recovery” (Support Worker 1, Focus Group B, Hamilton) while a team leader in Christchurch wondered if “the term recovery [has just] become another label” (Team Leader 5, Focus Group A, Christchurch).

Recovery and rehabilitation: Business as usual?

In most focus groups and interviews, participants unconsciously slipped from discourses of recovery, framed as person centred and empowering, to other discourses typical of rehabilitation or even medical models. Terms such as mental health and well-being were routinely conflated with mental illness and

addiction, symptom control and reduction in the prevalence of illness. This was even more evident in national and sector texts that drew on multiple translations that appeared to qualify a commitment to recovery in services without relinquishing other beliefs or intents such as biomedical expertise.

These allowed multiple translations to coexist, while situated interests and goals remained unchanged. The national mental health and addiction plan for 2006-2015, *Te Kokiri* (Ministry of Health, 2006) routinely drew on both recovery and bio-medical discourses within policy and strategy statements that were open to “interested” interpretations. For example, the same sentence that referred to mental health services being “built on a *culture of recovery and wellness*” goes on to refer to “participation by *people affected by mental illness*” (p. 2) and then introduces “a workforce that delivers effectively at the *interface between cultural and clinical practice*” (p. 2, emphasis added).

Similarly, recovery and rehabilitation were frequently conflated by research participants, especially by those with a background of clinical training. These were typically psychiatric nurses or occupational therapists, and they believed that recovery offered nothing new. One senior manager from Wellington admitted that her first response to a recovery discourse was to be “affronted as many clinicians were at the time” (Senior Manager 2, Wellington). Her understanding had evolved markedly over time, and she currently led a senior management team that comprised several people with lived experience of serious psychological distress. Unfortunately, much of the talk in focus groups and interviews indicated that recovery as rehabilitation was still the position of many clinically trained health professionals.

Two organisations explicitly used the Bio-psycho-social rehabilitation model developed by the Centre for Psychiatric Rehabilitation at Boston University (1994), and another unashamedly used psychometric assessments of staff and service users. However, senior managers in these organisations appeared to see no conflict between this and the recovery orientation mandated in national policy (Mental Health Commission, 1998; Ministry of Health, 1994, 2005). In fact several, especially managers, were explicit, even unapologetic,

that it was just business as usual. For instance a senior manager from Auckland admitted that when he “first became interested in [recovery] it was very much around [the] context of rehabilitation because that was what my training entailed” (Senior Manager 2, Auckland)

However, many others, and notably those from support worker and team leader cohorts, problematised the distinction between rehabilitation and recovery, and the power differential that it implied. They typically grappled with the functional and deficit based emphasis of rehabilitation approaches. Several also reported resistance from service users at having recovery done *to* them. They were concerned that recovery discourses, entrenched in psychosocial rehabilitation approaches, ignored important social, political and economic barriers to people participating fully in their communities, and placed undue responsibility for a person’s sense of well-being on their own efforts (Banks et al., 2004; O’Hagan, 2001, 2004). One team leader from Auckland remarked that, “Recovery is quite [different from] rehabilitation but sometimes those two things get confused”. She went on to add, “If someone had bulldozed me into rehabilitation I would have probably went the opposite way” (Team Leader 1, Focus Group A, Auckland).

In addition, participants were aware that multiple interpretations or translations of recovery had been evident from its introduction into national policy and this raised several issues for service users in particular.

Translating recovery

As discussed earlier, people with lived experience of serious psychological distress resisted the implication that they were returning to a point in the past, believing that the journey through madness was more a discovery of a new self and new territory (Leibrich, 2000). For others, it seemed *re-cover-y* was an injunction to “cover up again” and implied a requirement to hide their distress and experience: to be ashamed of it (O’Hagan, 2009). Still others did not accept that this profoundly human experience was an illness at all, and that recovery meant accepting bio-medical accounts and interpretations of their experience.

For some participants, ambiguity and vagueness had enabled dilution of the conceptual power of recovery, and those with clinical training and/or DHB backgrounds, particularly senior managers, appeared at ease with this blurring of the discursive boundaries as it enabled them to participate in multiple discourse communities. One explained that “the word seems to have had a substantive history in our communities” and it was a concept that “people are very comfortable with” (Senior Manager 2, Auckland). He saw it as “part and parcel of a natural process as people moved through our system of care” rather than a concept with important philosophical and practical ramifications for organisations.

Such constructions highlighted other on-going problems with the language, labels and translations of recovery that were evident within organisations and services. These suggested that despite language shifts, there had been little corresponding change in service practices. One participant stated, “We might call it all these lovely fancy lovey-dovey names, [but] to me it is still very clinical” (Support Worker 6, Focus Group PS, Wellington). It appeared that translations of recovery were regularly identified with Focus Group PS, medical story of mental *illness* in some organisations. A team leader from Christchurch commented: “There is a clinical version and then there is a version of recovery, or rehabilitation as some refer to it, and then there is the person’s version of it” (Team Leader 5, Focus Group A, Christchurch).

Participants were aware of the power of language and, to some extent, were cognisant of how the language of recovery was being manipulated specifically. As a senior manager from Christchurch intimated, “We shy away from some of the more contrived recovery language” (Senior Manager 2, Christchurch). Others, too, were aware of the ways that multiple discourses and translations were being used strategically to promote the appearance of a recovery orientation in mental health services, and equally aware that other priorities were actually driving the agenda. A senior manager from Christchurch noted,

Politically there is a big push [coming] from the Ministry of Health to move things out into the community and probably it is because of money. But their vocabulary is alright, they are talking about recovery and peer support and community support [and] that kind of thing. So the words are all okay.

(Senior Manager 1, Christchurch)

Similarly, most participants were conscious of managing multiple discourses and how these could be misleading. For example, a team leader was critical of her organisation's strategic use of language, aware that people "interpret language in different ways and can be influenced in different ways too". She added that her organisation's "description of itself it is an attempt to persuade you that this is their values and this is how they are going to conduct themselves in the community" (Team Leader 1, Focus Group B, Wellington) although she believed this public perception was false.

Differences in stance appeared to correlate with institutional insider or outsider positions on recovery. Insiders, for example those who had previously come from DHB environments, did not problematise the evolution of the recovery discourse or its absorption into the dominant translation; it was just the "way of the world". A senior manager from Auckland, who previously had a funding role with the DHB, remarked that most people were familiar with the "notion of having concepts come, many people being attracted to them, and then the concept goes and we have a resonance of it left [and] then we look to the next concept or the next philosophy that comes along" (Senior Manager 2, Auckland). However, others appeared to realise that something important had been lost inside multiple interpretations.

Natural evolution or fatally compromised?

The "talk" of participants, who were either service users themselves or whose organisations had strong service user leadership, drew on other, more recent discourses and suggested an evolution of thinking that was not apparent in the talk of other participants. Many of these "other" participants questioned

the relevance or power of a recovery discourse; making comments such as, “I think that there is a danger that the consumer voice is not going to be listened to as much in this environment because everyone is talking recovery” (Team Leader 1, Focus Group A, Auckland). This, and similar comments indicated the need for a privileged service user voice, to define or make sense of recovery in their own way. Alternatively, as Mary O’Hagan (2009) and others have discussed, services risked an insider appropriation of the discourse that rejected any privileged voice for service users. A senior manager from Wellington seemed to exemplify these concerns in saying that, “We shouldn’t make it something that academics or even service users capture and have as their own” (Senior Manager 1, Wellington).

Several other participants problematised the shifts in the recovery discourse and asserted the need for renewed power in the language. A participant from Christchurch expressed regret that recovery “has lost perhaps its meaning or its focus” (Team Leader 5, Focus Group A, Christchurch) and that change was needed for that reason. Although they seemed unaware that Mary O’Hagan (2009), a one-time mental health commissioner and long-time advocate in the international psychiatric survivor movement, has gone as far as referring to recovery as being fatally compromised or “colonised”, it seemed that this was their sense of what was pervading the discourse. Several participants made statements such as, “Recovery [sounds] all cheesy doesn’t it, because you are so used to saying it now” (Senior Manager 3, Wellington). He went on to say that, although he could understand why some people now thought it was “an idea of yesterday”, the barriers to genuine social inclusion and “living the life you want to live out there” still existed (Senior Manager 3, Wellington).

Translations of recovery also functioned as a form of strategic ambiguity (Eisenberg, 1984; Davenport & Leitch, 2005) and allowed participants and others from the NGOs to communicate and negotiate the interface with clinical and funder arms. It appeared that senior managers, particularly, were strategically negotiating multiple discourses of recovery, mostly to appear conciliatory and demonstrate organisational cooperation. A senior manager from Wellington

noted that in their communications with the DHB “there are two different languages and there is that extra tension too when the same language gets used in two different ways” (Senior Manager 4, Wellington). For some utilising this ambiguity was not seen as a problem, even where it reinforced the power of insider translations. For example, “We use the same vocab but we are actually attaching it to different discourses. [So] it is no surprise that different people in different parts of the sector use it in different ways and that is fine” (Senior Manager 2, Auckland).

However, for other participants, a requirement to adapt their language in order to participate in multiple discourses created considerable unease. Difficulties in negotiating the many tensions at discursive boundaries with clinical teams and funders were evident in the ways in which participants framed these encounters. For example, as a Wellington senior manager confessed, “If [another] staff member had heard me speaking those terms I would have felt really embarrassed; like I had sold out or something” (Senior Manager 4, Wellington). Or similarly, “I [had] to pull out all the deficit place stuff, otherwise they will not value what we do” (Team Leader 2, Focus Group A, Hamilton)

Most participants, other than workers with their own experiences of serious psychological distress, did not clearly articulate awareness that recovery as a discourse may have been compromised by more dominant translations. Instead, they tended to accept uncritically insider notions that recovery was becoming an outmoded concept, and this was even to be expected and accepted as natural. Workers with their own experiences of serious psychological distress, on the other hand, were far more aware that recovery had been colonised (Barker, 2003; O’Hagan, 2009; Wallcraft, 2009) by more powerful stories of illness and functional normality. These participants were introducing a new discourse of well-being, frequently expressed as an explicit rejection of recovery.

An emerging discourse of well-being

The emerging discourse of well-being suggested a new strategy for reclaiming the language of subjective experience. One senior manager explained

the evolution as, “We use recovery of well-being to give them a sense of some sort of journey: How they actually look at that experience and learn from it, and have some form of transformation” (Senior Manager 5, Wellington). This new discourse was apparent throughout the country but primarily from participants with lived experience of serious psychological distress. One peer support worker explained it as, “If you have well-being, then the deficit in your life, the illness in your life becomes less important, so [I just] focus on well-being a lot more.” (Peer Support Worker 4, Focus Group PS, Auckland). Another participant was explicit that this was a move away from a medical translation of the recovery discourse. He said, “Even the shift from using the word recovery [and] more the use of the word well-being, and a shift from the medical model [that] you are going to ‘recover’ from [an] illness” (Team Leader 2, Focus Group B, Auckland).

This shift to a discourse of well-being served several purposes. First, there was clear frustration, often explicit, that recovery was not being enacted in organisations in ways that people found helpful. Second, a discourse of well-being placed people’s experiences within the “normal” population and not outside it. Well-being was seen as something that everybody needs in order to thrive, and therefore removed the sense of people needing to *make up ground* before being worthy of a valued place in their communities. One participant from Wellington defined this explicitly in terms of the engagement that service users and the NGOs had with their communities. She discussed how their organisation considered the introduction of well-being in the sense of, “How does a nation, or community, develop a sense of how to support people’s individual well-being, [and then] how do the experiences of people who are not in a state of well-being mentally interact with all of that?” (Senior Manager 5, Wellington). Similarly, a team leader from a service user organisation in Hamilton explained how, previously, her whole life had become centred on her next clinical appointment rather than the well-being of her life as a whole. She was continually expected to delve “deeper and deeper into my problems [until] my whole life just became a problem and I thought I couldn’t do anything cool

until after I had sorted that out. So that's the difference" (Team Leader 4, Focus Group A, Hamilton)

It seemed clear, therefore, that important tensions have remained around multiple translations of recovery and whose interests these serve. This has meant a continuing lack of conceptual power for recovery as a model of practice for the community NGOs. In fact, this has been so much so that the original discourse communities of recovery, people who have had personal experience of serious psychological distress, have begun to turn away from it and have championed emergent discourses of well-being.

Conclusion

In conclusion, this chapter has addressed my first research question through an analysis of significant features of recovery discourses and the ways these were being constructed, negotiated and resisted by participants and the community NGOs. Fifteen years after the development of *The Blueprint* (Mental Health Commission, 1998), it might have seemed unequivocal that a recovery-orientation would be evident throughout mental health services in Aotearoa\New Zealand. However, the findings of this research indicated that multiple discourses of recovery are being used and contradictions exist between constructions of recovery expressed throughout the NGOs and the wider sector stakeholders.

The primary discursive conflicts among "models of madness" underpinned most other boundary tensions between the various interest groups and participants, and these echoed recent claims and arguments in literature authored by people with their own experiences of serious psychological distress (Adame, 2006; Gawith & Abrams, 2006; O'Hagan, 2009a, 2012; Pearson, 2004). For them, recovery was primarily concerned with issues of voice, identity and underlying rationality as they struggled to control the meaning systems, and reclaim the language, of their experiences.

For participants who had their own personal, lived experience of serious psychological distress, the stories of their experiences of madness were central.

They consistently described these events as intense, overwhelming and extremely difficult; but nevertheless deeply human, communicative and of value. Their constructions of madness described inherently complex and deeply personal phenomena that were intertwined with the evolution of recovery discourses; all of which constructions resisted others' accounts of their experiences.

Many participants drew on a metaphor of recovery as a unique and personal journey. However, for workers with lived experience of serious psychological distress, the recovery journey was highly contextualised and historical, and their talk was richly nuanced and organic in contrast with the almost clichéd sound bites of some other participants. This indicated that for these participants recovery language and discourses were constantly evolving as they struggled for control of their explanatory models. In contrast, other participants tended to construct recovery journeys as a measure of progress through mental health services, beginning only once people had entered services and expedited towards discharge. This limited a person's "history" to the narrow perspective of clinical accounts.

There was a general assumption throughout the focus groups, interviews and texts that Aotearoa\New Zealand mental health services were already recovery-oriented. This misconception was reinforced by national policy texts, which claimed that recovery "underpins services [and] recognises that service users must lead their own recovery, have personal power and a valued place in their whānau and communities" (Ministry of Health, 2006, p. 2). However, it was very clear in focus groups and interviews that these claims were exaggerated at best, and service users actually had very little real power over the important decisions that affected their lives.

It was clear that there was not a single, authentic or shared discourse of recovery. Instead, there seemed to be merely sets of common vocabularies and an assumption that "we're talking about the same thing" (Senior Manager 3, Wellington). Most focus groups appeared to be operating from multiple meanings, and translations of recovery and ambiguities and inconsistencies

frequently went unremarked. This also demonstrated that there were well-defined, if unarticulated limits to being recovery-oriented. In many cases, the language of recovery adopted in policy reforms appeared to be merely *translated* into other discourses with little change in practice and outcomes for service users. Participants were frequently participating in more than one of these discourses as they struggled to negotiate the boundaries with clinical services and funders.

Ostensibly, a recovery focus meant that the best outcome for service users in any mental health service organisation was to live an ordinary life in their community, with all the choices, opportunities and resources and rights of citizenship that this implied. Yet it was clear that there was considerable ambiguity to how this was being realised in practice. Translations of important constructs had significant effects and reinforced indications that there was still a significant gap between the expectations of service users for their recovery and what currently takes place in mental health services.

National policy and strategy texts tended to treat generic mental health services discursively, and unproblematically, as a homogenous set of organisations (Ministry of Health, 2005, 2006). The lack of differentiation between the NGOs and clinical services had the effect of attributing broad recovery aims, such as service choice and *living well in community* to all mental health organisations. Strategic vision statements, for example, included the importance of responsiveness, trustworthiness, personal choice, community engagement and service user leadership (Ministry of Health, 2005). However, it was clear from the focus groups and interviews that these concepts did not have the same meanings, conceptual power nor practice bases in the various organisations of the mental health system.

Despite this environment, the community NGOs seemed uniquely placed, and mandated by their trust deeds and constitutions, to support the aspirations of service users for a meaningful life within the communities of their choice. Unfortunately, their organisational missions and values were frequently in

conflict with, and regularly superseded by, contracting requirements and clinical priorities.

While progress towards a recovery orientation in organisational systems, structures and service delivery was evident in the community organisations, this was hampered by ideological constraints from other interests; constraints that have proved so persistent that many now regarded recovery as fatally compromised. For these reasons, people with lived experience of serious psychological distress were endeavouring to shift the discourse towards a health promotion model of well-being. The well-being discourse appeared to have emerged in response to generalised frustrations about the lack of noticeable change in the system despite the “talk” of recovery.

As early as 2001, Priscilla Ridgway was expressing a “growing concern that recovery may become the latest catch phrase used merely to reframe traditional activities, rather than evolving into a well-constructed paradigm that can effectively guide policy and practice” (Ridgway, 2001, p. 335). In the next chapter, I explore in more detail how these translations illuminated asymmetrical relationships that serve particular interests in the encounters with other, institutionalised and powerful discourses. There I further develop the argument that translations of recovery have allowed powerful interests to remain powerful; in particular, the DHB clinical and funding arms who are representative of biomedical discourses and managerial discourses respectively. It may be that recovery was *lost in translation* before it even began to transform mental health services in this country.

Chapter 7: Encountering the institutions

The language of psychiatry [has been] a monologue of reason about madness.

Michel Foucault (1973, ix-x)

Introduction

This chapter is concerned with my second research question and examines the evidence that demonstrated the persistence and power of institutional discourses and practices, even within the NGOs and despite the formal adoption of recovery as national policy in Aotearoa\New Zealand mental health services. In particular, I develop the earlier examination of the discourses and translations of recovery into an analysis of the effects on these discourses, usually positioned as alternative, when they encountered the powerful, institutionalised and macro-discourses of biomedicine and managerialism. In doing so I address my second research question: How are institutional dynamics working to construct, constrain or contradict organisational practices in terms of becoming recovery-oriented?

First, I revisit the complex nature of institutions and the evidence from focus groups and interviews that demonstrated their persistence and dominance throughout the Aotearoa\New Zealand mental health sector, despite formal policies of recovery (Mental health Commission, 1998; Ministry of Health, 1994, 2005). The evidence showed that naturalised and socially normalised assumptions underpinned the regulatory environment, and reinforced the cognitive pillars of the mental health institutions.

Second, I examine the ways that participants discussed *deinstitutionalisation* and how this seemed to be conflated with the sociological phenomenon of the 1970s and 1980s (see Chapter 2) and assumed an adoption of alternative models of community care in mental health services. Third, I outline evidence of the dynamics of institutional power that has enabled these to endure despite policy frameworks that mandate alternative approaches such as recovery. I contend that significant institutionalised features of biomedicine and managerialism have continued to control organisational discourses and practice

even within NGOs because, to varying extents, they were normalised or naturalised, even by participants.

I then analyse the impacts of institutional legitimation and authority on the relationships the NGOs, participants and service users have with clinical teams and funders from District Health Boards. In particular, I examine the issues that arose for participants and service users from the authority afforded these powerful institutions by the regulatory environment, and the mechanisms by which this authority was maintained throughout the community at large.

Normal and natural: Societal assumptions, myths of deinstitutionalisation and the normative institutional pillar

A Foucauldian awareness that the treatment of madness has been as much an act of social exclusion as it has been of medical practice has generally been absent from the wider social imagination. This has created a dilemma for mental health organisations, who are ostensibly supporting people to be in control of their own lives, and where recovery discourses are explicitly contrasted with coercive practices. For example, the *Blueprint* (Mental Health Commission, 1998) stated, “Recovery could never take place in an environment where people were isolated from their communities, where power was used to coerce people and deny them choices” (p. 1). Social isolation, therefore, has made it harder to shift social awareness about the nature of psychological distress, its precursors and what constitutes effective, helpful support.

Most participants equated the deinstitutionalisation of mental health care with the multiple translations of community and community care. In other words, deinstitutionalisation was typically constructed simply as the relocation of people into community neighbourhoods, and community care as merely a set of services beyond the hospital. These naturalisations represented the normative pillar of the mental health institutions, and illuminated the hegemonic relationships among mental health organisations, DHBs as agents of government, and wider society. This had important impacts on service delivery, particularly for the community NGOs.

The primary tension in participant discussions of community was between a sense of claiming a space in community, with expectations of *community* responsibility to accommodate all its members, and an institutional, socially normalised, construction of community. The latter positioned service users as outsiders needing to become functionally “normal” to re-join society. In particular, discourses of recovery that drew on rehabilitation models reflected societal expectations and institutional norms that emphasised an individual’s responsibility to become “fit for society”.

Becoming “fit for society”

Significant institutional features were clearly naturalised by many participants as societal assumptions, embedded in the normative pillars of both biomedicine and managerialism. Although this was often challenged by participants with lived experience of serious psychological distress, many accepted that the sustainability, and legitimacy, of their publicly funded organisations depended on their alignment with established socio-cultural and political norms, the legislative authority of biomedicine, and the naturalised attitudes of society. One participant articulated this as follows:

What we see as the mental health system is a reflection roughly of what society in general wants . . . some people want people with mental health to disappear and not be seen; some people want an intervention to stop abnormal behaviour, and for that to be managed, and some people want people to heal them and get better, and we have this mishmash of stuff. (Senior Manager 2, Wellington)

Participants often referred to stereotypes that still existed, the social pressure to be in paid work, and the stigma that services users continued to encounter.

Equally, the social normalisation of poverty for people with lived experience of serious psychological distress was of real concern to participants. A team leader from Wellington described the difficulties people had in, not only

“surviving with mental illness, but also with poverty as well. And it is almost like society says that is okay, and it isn’t” He described how hard it was to help people move out of their situation “when you have a whole society saying that is okay” (Team Leader 2, Focus Group A, Wellington).

Being “ready” for society was also a site of Orwellian-like control, the terms of which were conditional, arbitrary and without opportunity for redress. This clearly conflicted with the recovery principles of personal power and choice. In several stories, from a variety of regions, people made energetic efforts to effect desired changes in their circumstances, and meet the conditions they were told were necessary to do this. However, the goal posts were changed, or they were knocked back despite meeting the requirements. In two cases, this involved whether a service user would be “allowed” to have a pet in a home for which they were the leaseholder. A support worker from Wellington reported that the person had made all the changes to her fences required by council. She even had permission from Housing Cooperation, her landlord, to keep a dog. Somehow, her request was still rejected by her clinical key worker. “I just don’t think whoever is up there doing the number crunching actually knows what to do” she commented (Support Worker 2, Focus Group A, Wellington).

However, some participants also naturalised notions of being “in community” that did not seem to equate to the rights of citizenship; but instead suggested that people with lived experience of psychological distress were on a kind of probation. This construction of community care, also evident in significant national and sector texts (Ministry of Health, 2001b, 2005, 2006), emphasised functionality and the skills people needed to acquire, in order to become ready to re-join society.

This frame reproduced the notion of individual responsibility for well-being and was invariably associated with paternalistic notions of what “the community” expected of service users and services. Some participants accepted this uncritically. For example:

[This service] is about skill acquisition, confidence, knowledge building, resources, working for that individual.

Then they move onto the next step in their life, and then the next step. And I think the community also has a perception, not only of that sort of dangerous stuff around mental illness, but also that they need to be taken care of and protected.

(Team Leader 6, Focus Group P, Hamilton)

Some policy texts even referred explicitly to the community NGOs as residential rehabilitation services (Ministry of Health, 2001b). One senior manager unwittingly demonstrated the common notion that services needed to get people ready to be accepted into normal society by describing “living in a community of choice” as the reason the organisation focussed on their “healthy lifestyle coordinators” (Senior Manager 3 Hamilton).

In the section that follows, I extend the discussion of community and community care from Chapter 4, to examine how these constructions, or translations, normalised, challenged or perpetuated institutional power in mental health services.

Constructing community and community care

Normalised understandings of deinstitutionalisation and community care have assumed these to be nominally equivalent and logically consequent. Many participants and most national policy texts not only assumed that modern mental health services were community based, but that “the institutions” were a thing of the past. This popular misunderstanding of deinstitutionalisation has arisen because most people, including participants, thought of institutions in purely material terms, as large facilities in remote locations. People with mental health issues have been assumed to be “out in the community”, merely because “the institutions have closed down” (Peters, 2010, p. 10). It was commonplace for participants, and policy texts (Ministry of Health, 2005, 2006), to refer to current mental health services as “community based”, and “people with mental illness and addictions (being) cared for in the community” (Peters, 2010, p. 7) despite evidence that, for many service users, there was little engagement with ordinary community resources and opportunities.

Addressing barriers to community engagement for service users also appeared to be a reaction against expectations of a purely personal responsibility for health. Instead, some participants reported that their organisations were “trying to get communities to be better places for folk to live in and also more inclusive” (Team Leader 2, Focus Group A, Christchurch). A senior manager of an Auckland organisation argued that a lack of social participation was, “not all about people not being good enough or not being well enough” (Senior Manager 2, Auckland). Therefore, like some others, his organisation was endeavouring to counter community resistance by reorganising organisational resources and stretching their contracting boundaries through, for example, the creation of new “community development” positions in the organisation.

There were several ways that expectations of community care were constructed as “rehab readiness” (Senior Manager 3, Auckland), especially by clinical services. Major indicators appeared to be the abilities to budget, cook and keep their houses clean and there were many anecdotes of how support workers were treated like domestic help and held responsible for a person’s tidiness and general hygiene. Participants resisted, and even challenged, these expectations on the grounds of being discriminatory. As one Wellington team leader stated, there was “an expectation for people to have their houses spotless [and] I don’t know how people get this in their head that messiness is a sign of unwellness” (Team Leader 1, Focus Group B, Wellington).

A support worker from Wellington maintained that, “Expecting people to be tidier than I am it is really hypocritical.” She added that societal preoccupations with people becoming “perfect human beings” meant that, “Somehow recovery means you can cook, and you can clean and you can budget, and you know, and half of us can’t do that” (Support Worker 3, Focus Group A, Wellington). A senior manager from Auckland pointed out that judgements applied to the behaviours of service users could equally have been applied to him as a young man, exhibiting ordinary teenage behaviour. He acknowledged that although, in those days, he was “drinking and smoking far too much” no one

assumed that he should be “put under [guardianship control] for your own good.” (Senior Manager 3, Auckland).

Interestingly, workers with lived experience of serious psychological distress never spoke of community support work as *proving* oneself socially acceptable. But some fundamental attitudes were so naturalised that even some of these participants had internalised the idea of somehow being *deserving* of community life. “Like if you have done all your housework and you know it is spotless, and you have cakes and you have a teapot”, said a peer support worker from Christchurch (Peer Support Worker 5, Focus Group S, Christchurch)

Unsurprisingly, many service users had experienced “the community” as stigmatising and discriminating. Many participants argued that communities needed to take responsibility for acknowledging and embracing all their members. They were concerned about changing “the contamination, that thinking in the community” (Senior Manager 2, Hamilton). This theme echoed Patricia Deegan’s (1996) call for “the mainstream to become a wide stream”, and the notion of “opening communities to an idea that they can take responsibility for individuals that live in their community” (Senior Manager 2, Hamilton).

Participants generally observed that the environment, both within services and the wider community, was changing, albeit slowly and unevenly. Worryingly, however, they repeatedly echoed sector texts, which portrayed the institutional era as a sociological circumstance that was historical and irrelevant.

The “bad old days” have gone

Focus group discussions and interviews reinforced Rob Warriner’s (2010) concern that “people speak of ‘deinstitutionalisation’ in the past tense – as if we’ve done that, so what’s next?” (p. 73). Several participants referred to institutionalised service users as being the ones who had been in the “bins” thereby reinforcing a sense that institutions were mere physical buildings and environments.

Some participants commented that they “didn’t know enough about the institutionalisation days” (Team Leader 6, Focus Group P, Hamilton) and a

support worker from Wellington thought there was “not enough training on what institutionalised is, how it affects people and how to work with people who have been in long-term institutionalisation”. She went on to add, “Young ones don’t know anything about institutionalisation. All they know about is recovery.” (Support Worker 6, Focus Group A, Wellington), reinforcing the sense that institutionalisation was past, and a recovery-oriented mental health system was an established fact.

All these narrative fragments suggested that the popular discourses that equated institutions with buildings and communities with physical locations, had provided the appearance of change in the philosophy and practices of mental health service delivery while effectively obscuring the extent of institutional power that persisted. Therefore, despite expressing frustration at DHBs controlling the scope of their organisational practices, participants rarely framed these constraints as systemic; thereby excluding them from conversations that might have more effectively challenged the issues they faced.

Unfortunately, many aspects of the “bad old days”, particularly attitudes and stigma, appeared to have been transferred intact from the so-called institutional era into current mental health services, especially through staff who were re-employed in community settings. This caused concern for many participants faced with these attitudes, either within their own organisations or in relationships with clinical staff. For example, some support workers from Hamilton compared “the old school Tokaanui¹⁹ nurses” with staff who had not come from such facilities. When prompted to explain further one described this attitude as, “The authority approach: ‘This is what is going on’, ‘this is what is happening’, and sort of ‘like it or lump it’ ” (Support Worker 5, Focus Group H, Hamilton). Another added, “Yeah comply or things are going to get ugly for you, you know” (Support Worker 2, Focus Group H, Hamilton). However, although the harmful impacts of treatment services have been the subject of various Mental Health Commission publications (1998b, 2004) and public inquiries

¹⁹ See footnote p. 13.

(Brunton, 2004, 2005; Mason, 1988, 1996), participants were comparatively reticent about how peoples' recovery had been affected by such experiences.

In the next section, I examine how participants positioned themselves and their organisations in the face of institutional pressures, and the implications this created for their relationships with clinical services.

The institutions of the mental health system

The complex structural arrangements, discursive features and relationships of power that form institutions, are poorly understood by the general public (Johns, 2010; Warriner, 2010). Senior manager participants, particularly those from service user or kaupapa Māori organisations²⁰, were exceptions to this and could generally analyse and articulate clearly their awareness of institutional influences. However, senior manager interviewees from clinical backgrounds appeared more conflicted about the persistence of institutional influences.

The first major indicator of institutional persistence was the ubiquitous, yet incidental, referencing of the clinical aspects of mental health services by participants. This was more surprising because, beyond asking participants what they understood by the "medical model", no prompt questions were specifically directed at clinical services (see focus group questions guide Appendix 2). In these references, participants inevitably contrasted clinical services with what we do. This suggested that, despite widespread insistence that institutionalisation was a phenomenon of the past, biomedicine continued to have significant influence over the organisational life of participants and the users of their services.

Participants, especially support workers and team leaders, regularly referenced the biomedical model through the use of terms such as "clinical",

²⁰ See Appendix 9, but in brief, kaupapa Māori organisations that operate from an explicitly Māori worldview and cultural approaches to support such as working with families\whānau and communities, a holistic approach and a focus on relationship development between people and services.

“professional” and “expert”. This was noteworthy because the medical model itself seemed poorly understood, despite invariably being positioned as the antithesis of recovery. Naturalisation of the biomedical discourse was also apparent in the ways some participants focussed on deficits, problems and diagnosis in their exchanges with service users, even while speaking about recovery. Many seemed unaware that this was indicative of institutional influence over their discourse and practices, or of the contradictions between assertions of their organisation being recovery-oriented and the control that clinical services continued to exert in their organisational environments.

Regional variations were apparent, with participants from the larger organisations in Wellington and Auckland generally articulating a more nuanced analysis of these issues. Senior managers from elsewhere, also, were more often aware of institutional power; but they were equally likely to rationalise or justify the institutional environment because of their focus on organisational survival and sustainability. They were more likely to treat institutional constraints as a given and learn to navigate them and “get on with it”.

Participants with lived experience of serious psychological distress were far more conscious of the impacts of institutional persistence on service users’ well-being. One senior manager of a service user organisation in Christchurch, was well aware that medical priorities remained the norm, remarking that, “Whatever the problem is, the first look is at the medical regime, tweak this drug, add this drug, shuffle the diagnosis along. And we all know that it takes [more than that] in most situations” (Senior Manager 1, Christchurch).

It was clear that biomedical and managerial values routinely overrode recovery priorities when these values were in conflict. Some participants referred to “recovery being done Monday to Friday” (Support Worker 3, Focus Group B, Auckland), or only when it did not conflict with more pressing issues. Although participants acknowledged some of the issues were pragmatic, several commented that, “People are discharged from hospital, [just because] beds are full, they are discharged tonight.” This had serious implications for the services, families and other supports when they were being discharged. “The logistics of

getting family and the doctors and everybody together in half an hour are impossible”, this team leader added (Team Leader 1, Focus Group P, Hamilton).

In summary, despite the continuing references to established recovery-oriented mental health services in recent national texts (Ministry of Health, 2012, 2013; Mental Health Commission 2012a, 2012b), there appeared to be little evidence for substantive disruption of historically institutionalised, clinical discourses and practices in the Aotearoa\New Zealand mental health sector.

We already “do recovery” in mental health services

Many sector texts claimed that “establishing recovery-oriented services” (Mental Health Commission, 2007b, p. 7) was a success of the last decade. Participants, also, almost always referred to their organisations and themselves as “doing recovery”, seemingly unaware of the contradictions with other parts of the discussion where the locus of control of their own practice, their organisations and service users was clearly with DHB clinical and funding teams. For example, one Hamilton team leader described her organisation as “leaders in the field” and that they have “a philosophy that makes us different.” She went on to add explicitly that “the opposite of that is institutionalisation, which is ‘we have been there and done that’ in New Zealand” (Team Leader 2, Focus Group P, Hamilton).

In addition, many support workers and team leaders from particular organisations were somewhat unreflective in assuming that they and their organisations were already recovery oriented. Another team leader from rural Waikato stated:

(Our organisation) has always done things differently and has always challenged other organisations to see things through different eyes and because we are a leader, because [our organisation] does have recovery as an underpinning philosophy that actually gives us a mandate.

(Team Leader 4, Focus Group W, Waikato)

Participants did not seem to recognise that, if recovery was genuinely effective in driving the discourses and practices in these organisations, substantive shifts in power should have been evident. In particular, it should have been apparent in NGOs, through changes to the ways resources are mobilised in the sector and development of their autonomy in the design, development and delivery of their services. In other words, as the Mental Health Commission (2007) discussed, there would be evidence of mental health services “working to ensure that everyone is empowered; that we all have increased control over our lives, and can actively participate in our communities” (p. 12). Instead, participants articulated their frustrations at the issues they faced as discrete rather than systemic. They did not identify, for example, the ways in which systemic processes of access to services, diagnosis, treatment and discharge might be incompatible with ideals of recovery in mental health organisations.

Instead, while most participants talked of service users having choices, this was clearly within a fairly narrowly proscribed range of options controlled by organisations in response to either contracting or clinical team requirements. In the worst cases, personal choice was arbitrarily removed and this was frustrating for participants. One senior manager was clearly irritated by inflexible regimes that impacted unnecessarily on a person’s autonomy in their daily life. He declared, “Show me where it is written; show me the psychiatrist that will swear, on oath, that this person has to have their meds at seven o’clock. Yes, there are some medications that need to be 12 hours apart. So move the next one back a couple of hours” (Senior Manager 3, Auckland). Examples such as these indicated that there has been no significant reduction in clinical control and the community organisations. Far from being organised around an emergent recovery model, most continued to operate under rigid institutional constraints.

It was equally evident that their recovery efforts were routinely undermined, and NGOs treated as subordinate to clinical services by both the clinical and funding arms of the District Health Boards. This was stated explicitly in this example:

We strive to work in a recovery-focussed way and strengths-based practice way with people, compared to clinical services who are required to work with people in a very clinical way, and the notes you see from doctors and nurses and notes from files that come through, it is very hard for them to write in a recovery-focused way from a clinical perspective because their focus is medical model.

(Support Worker 2, Focus Group H, Hamilton)

Such interactions illuminated a whimsical binary between clinical needs and recovery support needs where clinical needs were treated as primary and superior. Yet these excluded or ignored much of the contextual, personal and practical considerations that were central to the daily lives and well-being of people in their care. Several participants provided examples of discharge arrangements that illustrated these frustrations. A group of team leaders from Hamilton had this exchange:

(TL5) It is stressful for our staff, who get a phone call saying,
“Can you come and pick him up?”

(TL2) Because a lot of times it is at four o'clock

(TL5) On a Friday

(TL2) And you know the person doesn't have any food in their home or anything like that.

(Team Leaders 2, 5, Focus Group A, Hamilton)

Claims of recovery orientation in services, therefore, seemed premature at best. Some participants saw positive change in both services and society, but this was by no means the norm and several commented on the slow pace of change with one commenting that, “Clinical teams are now learning about recovery three years ago they didn't know” (Support Worker 10, Focus Group A, Wellington).

In several cases, the persistence of institutional legacies appeared unremarkable to some participants. One senior manager of a residential service

described the recent removal of signage, “the staff house, and this is the staff toilet, and this is the staff fridge” (Senior Manager 6, Auckland) as an example of significant organisational change. He seemed unaware that most people would assume that such archaic labelling had been removed long ago. All of which suggested that, despite national policy and the assumptions of recovery-oriented mental health services, change has not only been very slow in coming, but appears to have lacked a sector wide will or strategy.

The community non-government organisations are different

Despite the rhetorical focus on “community” in mental health services, it seemed clear that the role of NGOs was rarely acknowledged, let alone validated within the mental health system. Sector texts appeared to blur the boundaries by, for example, referring to “the community mental health and addiction sector at work in New Zealand” (Peters, 2010; Ministry of Health, 2005, 2006, 2012, 2013). This stratagem not only conflated mental health with mental illness and addiction but further reinforced notions of community services being merely geographical relocations of clinical services. Mental health sector consultant, Janet Peters, was not alone in further muddying the discursive waters of *community choice* by stating, “The core business of many NGOs is to support people who have mental health and addiction problems to live the best possible life in their community of choice, despite the [at times] disabling consequences of mental illness” (Peters, 2010, p. 3).

Participants unequivocally distanced themselves from in-patient clinical services. For them hospital was a stalwart of the institutional era and life on the “outside” was a different world. They were frustrated that clinical professionals “don't know what it's like out in the world for a person who's just got out of hospital” (Senior Manager 4, Hamilton). In addition, a lack of collaboration at the boundaries between clinical and community services was reflected in the “variable alignment and integration between services provided by DHBs and those provided by NGOs” (Ministry of Health, 2012, p. 3) in terms of people's movements into the community from in-patient facilities. This was a source of frustration for participants who positioned themselves, and their organisations,

as explicitly concerned with the successful reconnection of people with their communities and the lives of their choice.

Evidence of the persistence of institutionalised practices was even more apparent when some of the barriers were removed. A support worker from Wellington described what it was like when people discharged from in-patient facilities began to realise they didn't need to see permission for everything they wanted to do. She said,

When they start making decisions and stuff for themselves, it is like, 'Oh my god I can do this.' And that was after years of having it drummed into them, 'you have to come and have tea at this time', 'you have to peel spuds at this time'. [Its] just things that we take for granted.

(Support Worker 7, Focus Group A, Wellington)

Institutional intransigence was not, however, merely a feature of the normative aspect of mental health organisational discourse and practices. It was also represented by a formidable body of institutional knowledge. In the following section, I explore more deeply how participant talk highlighted the cognitive pillar of the institutions.

Enduring and persistent: The cognitive pillar and bodies of knowledge

As I discussed in the literature review, the persistence of institutions lies in their power to define the nature of knowledge, rationality, and legitimate inquiry in ways that become socially normative. This is referred to as the cognitive pillar of an institution (Maguire & Hardy, 2009). Institutional bodies of knowledge not only include significant texts, but also draw on particular rationalities and discursive practices. There was perhaps no better evidence of institutional persistence in mental health services than the naturalised reification of mental illness; to which nearly all national texts referred and into which usage many participants slipped unconsciously. The cognitive pillar of an institution also holds to itself the power to accredit professionals and define what counts as expertise. Many participants, while articulating multiple frustrations with clinical

services, continued unthinkingly to refer to clinical knowledge and expertism as somehow higher or superior.

In this section I examine how participants constructed and referenced the medical model and clinical services; in particular the influence that naturalised acceptance of the superiority of clinical knowledge had on their organisational environments. I also compare these perspectives with the ways in which significant sector texts constructed concepts like biomedicine and recovery and the degree to which these perpetuate institutional knowledge and notions of professionalism. In addition, I explore how participants referenced the effects of managerialism in Aotearoa\New Zealand mental health services.

Common sense: The taken for granted aspects of institutional knowledge

Participants made distinctions between those environments where the medical model was naturalised and those where it was resisted or challenged. A team leader from Hamilton explained that, “Now I am working for the DHB I have to work really hard not to get co-opted by that medical model”. She and her fellow social workers were conscious of having “think constantly in strength based language. Not to have that clinical language impact” (Team Leader 5, Focus Group A, Hamilton)

National texts reinforced the taken-for-granted, biomedical assumptions of the reification of mental illness as organic disease stating, for example, that “mental illness accounts for 15 percent of the total burden of disease in the developed world” (Ministry of Health, 2005, p. 1). Similarly, these texts regularly associated terms such as “mental health and well-being” with “mental illness and addiction”. Statements such as “good mental health and well-being is more than the absence of mental illness or addiction” were similarly juxtaposed with assertions that “understanding mental illness and addiction in the general community is critical” (Ministry of Health, 2005, p. 12).

In focus group discussions, fragments of larger narratives (Boje, 2001) about the medical model and clinical authority were evident and numerous, yet participants seemed bemused when asked directly about these issues. This

seemed to indicate considerable naturalisation of the role and superiority of biomedicine even where this was resisted in more self-conscious talk. A degree of naturalisation was also evident even within larger humanitarian discourses and strengths based practices. A deficit framing of peoples' experience was often repeated unreflectively. For example, "I think you need to identify your weaknesses and that way you grow" said a Wellington support worker (Support Worker 5, Focus Group A, Wellington). Such comments occurred alongside the continued reification of mental illness, "Yes they have an illness, but they are also human beings" (Team Leader 3, Focus Group A, Auckland). Sometimes even stigmatising language went unremarked. For example, another support worker remarked, "I don't actually really think that I have ever met anybody that is mental forever" (Support Worker 8, Focus Group A, Wellington).

Internal contradictions and ambivalence were also apparent and fragments of biomedical narratives were embedded in more general discussions of support and recovery. This suggested that discourses of recovery were being subsumed by larger institutional narratives. For example, while many participants were clearly frustrated with clinical attitudes and relationships of control most did not actively challenge clinical expertise but accepted that authority in a person's life. Even a peer support worker, who was dismayed by how many service users felt they were not listened to by psychiatrists, and how hopeless that made them feel, remarked "it is just a shame that we are not clinical and that we are not trained in that area" (Peer Support Worker 5, Focus Group S, Christchurch). This comment valorised the status and authority of clinical knowledge rather than the biomedical model itself.

The social valorisation of a biomedical construction of experience had other serious implications as recent changes to Accident Compensation Corporation (ACC) legislation, which now requires a clinical diagnosis of mental "illness" for survivors of sexual abuse to be eligible for funded counselling, have demonstrated. This was clearly causing alarm among peer support workers in particular. One even believed that "there is going to be a higher rate of suicides.

I mean who wants mental illness when you don't need to have that" (Peer Support Worker 9, Focus Group PS, Auckland)

The naturalisation of biomedical constructions seemed to make it more difficult for many participants to recognise and articulate the institutional synergies that impacted on their organisational environments and individual practices. In the next section, I examine how participants constructed the biomedical knowledge base and the role this played in their own practices.

Bodies of knowledge and the "medical model"

When asked what the medical model and its influence on mental health services meant for them, many participants responded in terms of medication, diagnosis and deficits. Typically, the medical model was defined or described as, "A clinical approach. Treatment, treatment focused, treatment based; the word that very much comes to mind is like 'authority over'" (Support Worker 2, Focus Group H, Hamilton). Workers with lived experience of serious psychological distress were generally the most articulate and nuanced in their discussions of the medical model and many senior managers seemed aware of its more complex institutionalised power and influence. However, many support workers and team leaders also responded to direct questions about the medical model with rather surprising naiveté and defined it in quite narrow terms. Several made vague comments such as, "It would probably be, in my view, more around the treatment regime, the medication, and assessing where you know the disability or whatever is at, that sort of thing" (Support Worker 6, Focus Group P, Hamilton). This was surprising given that elsewhere in the discussions they made numerous incidental references to "clinical knowledge", "clinical talk" and the power of clinical teams in controlling their everyday organisational communications and practice.

Biomedical knowledge and language were perceived as technical "jargon, big words" (Support Worker 3, Focus Group H, Hamilton) that were both alienating and exclusive. One senior manager remarked that "speaking in more clinical terms to other people" (Senior Manager 4, Wellington) was

uncomfortable for service users and staff who were used to her speaking in more recovery-based language. Others were clearly frustrated by language they perceived as deliberately and unnecessarily complicated. In particular, as one support worker remarked, “It is not an easy language to understand. You get words like oedema and you know extra-pyramidal you know dah-di-dah, instead of saying ‘the person has got tremors in their hands’, what is so hard about writing that?”. She went on to add that, “The one that really gets me is ‘non-compliant’. Why can’t people just choose not to take their medication for [a given] reason, and work with them around that” (Support Worker 3, Focus Group P, Hamilton).

A reliance on biomedical language and knowledge also had the effect of depersonalising people and reinforcing an identity of “patienthood”. This team leader commented only looking at “nurse things” or “doctory things” meant that “because you're only looking at a little bit of a person, it’s easier not to treat them like a person” (Team Leader 6, Focus Group A, Hamilton). However, it was also clear that an ability to manage the biomedical discourse was necessary in order to be credible and effective. For instance, another Team Leader complained that “I [have] to pull out all the deficit place stuff; otherwise they will not value what we do” (Team Leader 4, Focus Group A, Wellington).

Most participants framed the medical model as being concerned with control, and particularly with symptom control and behaviour management predicated inevitably on a model of reified organic disease. A support worker from Christchurch was disparaging about the “quick fix” of medication that meant people “calmed down and [became] more manageable okay. And that is where it is at: Because it is about the manageability of the people” (Support Worker 3, Focus Group S, Christchurch). Others were equally explicit about the tensions, even power struggles, between recovery and bio-medical approaches, with one Hamilton support worker saying that the medical model “is almost the be all and end all, you know and I think the recovery model [works] around that” (Support Worker 2, Focus Group P, Hamilton). This was also troubling when it came to finding recovery outcome measures. A senior manager was concerned

that clinicians were just using HONOS and, “no other measures being used, and it sounds like there is not a kind of spirit of looking for other measures” (Senior Manager 5, Wellington).

It was evident, therefore, that biomedical accounts of people’s experience were still dominant in directing the delivery and development of mental health services including the NGOs. In the next section, I examine the evidence that shows how biomedical stories of diagnosis, treatment and prognosis continued to be prioritised throughout the sector.

Diagnosis still the most important story

Institutional definitions of mental illness, based on assumptions of organic disease and objective biological indicators, led inevitably to the intransigent role of psychiatric diagnosis in determining a person’s mental health status and explained why it has remained the most important “story” in service referrals, needs assessments and discharge plans. Although participants frequently accepted the reification of mental illness, it was also resisted: “Because it is the medical model, everyone is seen as if there is something wrong with them” (Peer Support Worker 1, Focus Group PS, Auckland). This interpretation of people’s experience was vigorously challenged. A team leader from a service user organisation in Hamilton commented that, “We’ve all talked about not owning the label or diagnosis; wearing it on our foreheads, on our sleeves; wherever we go we’re known by our label” (Team Leader 1, Focus Group A, Hamilton).

Participants had serious doubts about the limitations of diagnostic categories and the ways that subjective experiences were inevitably decontextualised. Too frequently this led to unnecessary medicalisation of common human dilemmas and the fear that people “can’t have normal emotions because the mental health system will put [them] in hospital’ [when] they are just grieving over the loss of someone” (Team Leader 2, Focus Group A, Auckland). Another participant echoed this anxiety over the impact of medical classification in saying that, “Once you become a diagnosis you lose a sense of

self-worth and if you take on that role of the diagnosis, a label that someone's put on you, you begin to act and behave accordingly" (Team Leader 4, Focus Group A, Hamilton).

The persistence and power of a diagnosis created the most concern with one peer support worker saying that "diagnosis a lot of the time that just finishes you off" (Peer Support Worker 6, Focus Group PS, Auckland) and another describing it as a "death sentence" (Peer Support Worker 3, Focus Group PS, Auckland). It was also mistrusted as an adequate, or even accurate, explanation of a person's experience. For example, "They tend to get it wrong all the time, 90% of the time it is not really what it is [and] it follows you around for 20 years" (Peer Support Worker 1, Focus Group PS, Auckland)

Participants from all regions and organisations repeated these themes in most focus groups. One senior manager reflected that diagnostic labelling seemed to be more about territorial boundaries than any therapeutic benefit, saying, "There is a whole pile of normal human emotion and human response that our mental health system view as being somehow their territory" (Senior Manager 2, Christchurch). Several participants challenged this territorial exclusion and alienation through advocacy. For example, a team leader in Hamilton remarked that she would "actually stop the psychiatrist, turn to the person and say, 'Do you understand what's happening?'" (Team Leader 5, Focus Group A, Hamilton).

Unfortunately, it was clear that "mental health labels" and constant references to being "ill" were also internalised by service users themselves. This internalised stigma interfered with people recovering and re-building self-confidence, becoming somewhat of a self-fulfilling prophecy as the following example shows. A support worker from Wellington remarked that service users often "think there's a magic pill" and became anxious to see a doctor or "do something about it [when they] probably had a headache and a lot of people do" (Support Worker 7, Focus Group A, Wellington)

In general, participants talked of human experience being more useful as "knowledge" than diagnosis, and clinical knowledge on its own was portrayed as

a narrow and rigid framework that restricted participants' ability to work with people from within their own explanatory models. This appeared to require a very different kind of encounter, one that recognised that "some people are extremely sensitive and have a wicked intuition. And you are telling them that they are haywire, because they have some gifts that they have actually grown up with" (Support Worker 3, Focus Group W, Waikato). In addition, excluding contextualised knowledge and other sources of expertise frequently had negative implications for service users and workers. The narrow lens often prevented them from working in more holistic ways and frequently did not acknowledge or value the work they did.

The narrow lens: Evidence based practices and treatment options

The reification of mental illness raised other epistemological issues, such as the research agenda and what counted as legitimate approaches to inquiry. Biomedical research has continued to valorise positivist methodologies into the origins, biological markers, "cures" and treatments and this has meant that the biomedical lens has had a narrow, decontextualised and depersonalised focus. This, in turn, has led to narrow treatment options, specifically pharmacological treatments, and fed into the increasing clamour for evidence based practices. The Mental Health Advocacy Coalition (2008) expressed their concern in saying that, "Evidence about mental health services and treatments comes primarily from a narrow quantitative base, and ignores the subjective experience of people who use services" (p. 27).

Many participants spoke of various theories and approaches being applied in mental health services over time yet it was apparent that service users had little control, or even input, into evaluating these. As one worker said, "I have been in the system for so long, have seen so many different theories, things that have worked, some that haven't" (Peer Support Worker 9, Focus Group PS, Auckland). The national mental health and addiction plan was explicit about expectations of, and reliance on, "on-going developments in technology, from changes in pharmacology to new ways of gathering, managing and sharing information" (Ministry of Health, 2006, p. 2). This preoccupation with

technological solutions was at odds with the intent, also expressed in the national plan, of “a recovery philosophy that underpins services for people and recognises that service users must lead their own recovery, have personal power” (Ministry of Health, 2006, p. 3). Many participants seemed aware of these environmental pressures, with a team leader from Auckland commenting that “psychopharmacology I think is winning - the drug companies have a lot of money” (Team Leader 2, Focus Group A, Auckland).

Yet despite the valorisation of medication, there was little support for the notion that this was necessarily beneficial. Participants, especially those with lived experience of serious psychological distress, expressed frustration at the ubiquity of medication and particularly its inefficacy for many people. This peer support worker was especially insistent that, “To be honest if medication works, if it cured it, we wouldn’t have a job because *everyone* we work with is on medication, everyone!” (Peer Support Worker 7, Focus Group PS, Auckland). Not only was medication usually the only treatment option provided but alternative practices, experienced as beneficial by service users, were either actively discouraged or simply not funded. A peer support worker expressed her regret that “all those other things that could really change someone’s life; but they can’t pay for it themselves and it is not going to be funded because it is not medication you know” (Peer Support Worker 6, Focus Group PS, Auckland)

Many participants also spoke about negative and harmful effects of medication, but it was apparent that they had little power to effect change in prescribing practices. Several commented that increasing medication was the knee jerk reaction of most professionals to any change in mood or life circumstance. One disclosed that she, herself, had been “going through a rough patch and [the doctor’s] first initial thing was to go back on medication. . . . I felt let down by her at that stage” (Peer Support Worker 1, Focus Group S, Christchurch). Another protested, “I get so sick because it is the medication that is causing half of it; you can’t function and can’t think” (Peer Support Worker 1, Focus Group PS, Auckland).

Similarly, the side effects of many medications were frequently antithetical to recovery goals of full participation and regaining valued roles in their communities. Another support worker from Christchurch said, “The medications they get given actually prevent any realistic view of going back to work. I mean a lot of the medications make people very lethargic” (Peer Support Worker 3, Focus Group S, Christchurch) and another from the same focus group added, “I couldn’t read; now I can actually read again. I was on medication for years, so it can stop you doing a lot of things” (Peer Support Worker 1, Focus Group S, Christchurch)

Where people experienced medication as helpful, this often seemed to be a matter of luck rather than an evidence-based process. An Auckland support worker explained that a person she worked with “had one positive experience from medication from a long history of really bad reactions just making her feel worse” (Peer Support Worker 6, Focus Group PS, Auckland). Several participants were explicit that service users “didn’t get to choose what type of therapy or approach; they don’t get to choose the medical model, they get given the medical model” (Peer Support Worker 2, Focus Group PS, Auckland), and even when they asked for other therapies these were not generally provided.

Most participants were aware that other therapeutic activities were consistent with a recovery philosophy and approach. But these were neither universally, nor systematically, available and depended on regional service configurations and \ or the predisposition of individual clinicians. This was despite the explicit acknowledgement of the need for “talking based therapies” in national policy texts (Ministry of Health, 2005, 2006). A peer support worker from Auckland stated, “Theoretically, talking therapies are meant to be available to anyone who is in mental health services, but they are not” (Peer Support Team Leader 2, Focus Group PS, Auckland). In addition, when alternatives were offered these could be conditional on compliance with clinically preferred options such as medication. Several participants, mostly workers with lived experience of serious psychological distress, talked about experiences of overt coercion regarding treatment. Several participants told stories similar to this one

from Auckland where, “If I didn’t go to the group that taught DBT (*Dialectic Behavioural Therapy*) I didn’t qualify for one on one [therapy and] there was a contract which had never been made clear to me, that if you miss two [group sessions] you get cut [from one-to-one therapy]” (Peer Support Worker 1, Focus Group PS, Auckland).

Narrow evidence-based treatment parameters also contributed to the sense, expressed by multiple participants, that something important was lost when service users interacted with clinical services. Participants were mistrustful of the narrow focus and this created conflict even within clinical services. One senior manager spoke of his experience in a clinical alcohol and drug service, explaining why he eventually resigned. He said, “When I went to CADS [*Community Alcohol and Drugs Service*], all this pain and marmite coming out of people, and I had to tell them ‘I can’t deal with it, I can’t do anything about it . . . because if I put it in my notes I’d get challenged on it: ‘What are you doing? You are [not] a social worker’” (Senior Manager 2, Hamilton). Most participants alluded to constraints on their practices that were at the expense of more recovery-oriented or contextualised accounts of experience. This also suggested that while clinical responses typically “claimed the territory”, they remained averse to including, or even referring to, other services in their repertoire of responses. In the section that follows, I examine the evidence of institutional capacities to define what counted as expertise and the notion of “professionalism”.

Expertise and professionalism

Participants constructions of the concept showed that the notion of “doctor knows best” was both problematised and normalised. National policy and strategy texts, for example, routinely referred to the need for more clinical expertise based on the construction of madness as illness. These continued to valorise clinical services, despite their overt aims for recovery-oriented services (Ministry of Health, 2005, 2006). Even Janet Peters (2010), who explicitly championed the community non-government sector, appeared to accept that “a dwindling clinical mental health/addictions workforce is a critical problem” (p. 8).

Recent trends to address this deficit have included the transfer of care to primary providers such as general practitioners. However, this has not challenged the foundational assumptions of the biomedical model and the superiority of clinical professionals.

All of these aspects were evident in participant talk and one senior manager expressed frustration about the systemic interaction between managerialist and biomedical priorities that resulted in some seriously negative consequences for service users. This senior manager described concerns she had in her region saying:

We hospitalise people much more than anywhere else in the country, and we have got beds so they have to be full. We have more psychiatrists than anywhere else in the country per head of population, so you would think that people would be very well cared for and have one of the higher levels of mental well-being in the country. We don't have that; all we have is the highest levels of prescribing in the country. (Senior Manager 2, Christchurch)

Although most participants consistently resisted professionalism and professionalisation they seemed unaware that the relationships between professionals and others were embedded in institutional dynamics. However, they were aware that professionalism defined structures of power. As a team leader in Auckland remarked almost nonchalantly, "I mean that is part of the medical model; a very hierarchical sense of your position which determines how much power you have" (Team Leader 4, Focus Group A, Auckland). Most also recognised that this hierarchy of knowledge and expertise subordinated NGOs and support workers, and worked against emerging discourses and models of recovery. For example, a support worker in Hamilton explicitly referred to "a hierarchy though with the medical profession" and that meant that the doctor had unilateral authority because, "He is at the top of the tower. And while the tower should actually have the person [at] the top of the tower, the doctor sits there" (Support Worker 3, Focus Group P, Hamilton).

Participants had strong ideas of what being professional meant, and that this set clinical teams apart from service users and community sector workers. Workers with lived experience of serious psychological distress commented on feeling disoriented by having to “look a certain way, you have to be a certain way; you can’t be professional and suffer from a mental illness” (Peer Support Worker 4, Focus Group PS, Auckland). Another participant from the same focus group commented on the difficulty in defining professional when he first became a peer support worker. He was worried that he would “have to act professional and all this? Which isn’t me.” (Peer Support Worker 7, Focus Group PS, Auckland).

Focus group discussions invariably framed clinical professionals as *the other* and it seemed clear that there was considerable mistrust in the relationships between clinical teams and workers in NGOs. A support worker from Wellington commented that while relationships have improved initially she said “[I] used to get quite defensive when I was working with them, they seemed to focus on what they wanted rather than what the person wanted” (Support Worker 6, Focus Group A, Wellington). The mistrust was mutual and some clinical staff in the NGOs found themselves in a mediating role. For example, one clinically trained service manager remarked that, in order to reduce anxiety on the clinical team, “We need to play the ‘I am a registered health worker’ card, you know, here let’s all do this together great [. . .] so we do some of that cushioning; greasing the wheels is probably a better word” (Senior Manager 1, Auckland)

Others were cynical about what professionals could offer and a team leader from Auckland commented that it was easy just to make a diagnosis and say “pop this pill, and come back in three months’ time” (Team Leader 5, Focus Group B, Auckland). Prescribing medication also seemed to create a particular dilemma of professional expertise and the primary role of clinicians. One senior manager was quite scathing in stating that, “Why would you say medication is no good if you are a psychiatrist. What on earth are you going to do then?” (Senior Manager 3, Auckland).

Being clinical, or professional, seemed to mean discounting the value of relationships. As one senior manager admitted, “I guess because we have had a more sort of clinical focus in the past we haven’t really pushed the relationship side of things” (Senior Manager 3, Auckland). Many participants echoed this as a major distinction between clinical and NGOs. Another senior manager, from Hamilton, cautioned against focussing solely on outcomes before getting to know the people they worked with. He insisted that for his organisation the “investment [in] relationships” was “essential to therapeutic practice” (Senior Manager 2, Hamilton).

Resistance to being “professional” seemed to be based on a resistance to an assumption of authority over others experience, and anxiety service users expressed about being handed over to a system from which it would be impossible to extricate oneself. Insistence on professional boundaries was also perceived as a demarcation zone and ultimately unhelpful for service users. A Wellington support worker believed that clinical staff had “control issues” (Support Worker 3, Focus Group A, Wellington) and this meant they were not willing to learn anything outside their field of expertise.

While it was clear that, some professionals from within clinical services established trusting relationships with individual service users, as a general rule these encounters were avoided. Many participants reported that service users mistrusted anyone who might be perceived as professional and this reluctance was a direct consequence of the (mis)use of professional power. They observed that service users experienced these encounters as negative and unhelpful if not, sometimes, downright harmful; although, they were anxious about what the system could do to them if they were “non-compliant” and many actively hid their symptoms. One team leader remarked, “I think they’re a little bit frightened that we’re going to talk like a doctor to them. They never open up to doctors anyway” (Team Leader 1, Focus Group A, Hamilton).

Many encounters with clinical services were reported as demeaning and disempowering. Peer support workers from Christchurch discussed how humiliating it was when they went into the psychiatric emergency department

and “the receptionist tells you to press a button by the door, and a speaker comes on and says, ‘What do you want?’, and you have to say in the reception area where everybody is sitting why you need this service” (Peer Support Worker 2, Focus Group S, Christchurch). There were also examples of a kind of professional arrogance where doctors made diagnostic decisions without evidence. For example, “This person has denied hearing voices, delusions or hallucinations. It just irritates me that they have that right to say, ‘this person has [schizophrenia] but has just refused to admit it’.” (Support Worker 3, Focus Group P, Hamilton).

Similarly, there appeared to be little space within the system for trusting someone’s own expertise, despite good evidence that this could be effective. A team leader from Hamilton talked about a neighbour who had previously had hospital admissions but did not want one this time. Instead, “She wrote out her own plans; who her contacts were and she had support from an agency. She did have an admission, but it was the shortest one that she has ever had in her recovery” (Team Leader 5, Focus Group P, Hamilton).

Assumptions of the legitimacy of clinical services appeared to protect them from accountability. This could include a continuum of responses from routinely over-riding others’ concerns, to devastating consequences including even death. At the lower end of this scale, the capacity of support workers to intervene or advocate for service users in traumatic circumstances was severely limited. One Christchurch support worker was very upset at feeling powerless, “because I haven’t got letters behind my name and no-one takes me seriously [but] they shouldn’t have been sent to hospital” (Support Worker 1, Focus Group S, Christchurch).

In addition, at the extreme end, some participants were distressed they did not have the power to intervene in literally life-threatening situations. A support worker from Wellington was distraught that over several years a client was treated as a hypochondriac when she complained, “that her throat was thick all the time, and she died saying her throat was thick”. Sometime later, this worker encountered other service users who said the same thing. This prompted

her to do some basic research and she found it was a known side-effect of a common anti-psychotic medication. She discovered the medication “affects the central nervous system of the throat and [they] can’t swallow properly and that is why they think they are choking”. This was clearly upsetting for her because, “that poor lady, for all those years you know, and they just said she was a hypochondriac” (Support Worker 7, Focus Group A, Wellington). Despite such examples being major concerns for many participants, clinical, national and policy texts have continued to disregard the iatrogenic effects of treatment services.

Seeking professional help also seemed to be a double-edged sword. People would only be helped once they had gone through the clinical assessment and referral “gate”, but once through that gate they surrendered control of many major decisions affecting their lives. In addition many reported concerns that “mental health patients aren’t allowed to hate the professionals” (Team Leader 3, Focus Group A, Hamilton) alongside a fear that dysfunctional relationships would be pathologised and they would be “blamed”. As one team leader said, “They get told, ‘you are being ‘behavioural’, ‘you are unruly’.” (Team Leader 3, Focus Group P, Hamilton). This was also disempowering and one senior manager spoke of service users being trained, or institutionalised, into deferring to clinical expertise.

Participants who had come to the NGO sector from clinical backgrounds were uncomfortable about the differences in approach. One senior manager from Christchurch expressed her regret that clinical interactions were at odds with recovery ideals, saying that, “The real barrier to people’s recovery is clinical services at the moment, and I feel quite sad about that given that is where I have come from to this work”. She went on to add, “I don’t see much about the way they interact with people, about the types of treatments offered that speak to me of recovery” (Senior Manager 2, Christchurch).

Despite fifteen years of rhetoric about recovery, it was apparent that real change has been slow in coming and was certainly not systemic. As one support worker remarked, “The clinical teams are *now* learning about recovery” (Support

Worker 2, Focus Group A, Wellington). But there was evidence that in places things were changing, and that particular individuals were making it work effectively. Some participants reported that some “psychiatrists seem much more willing to adjust medication and respond to what the clients are saying” (Team Leader 6, Focus Group A, Auckland). Certainly, everything appeared to work more successfully when everyone was involved in communication and decision-making. This team leader from Hamilton was enthusiastic about the approach, and successful outcomes, of a particular psychiatrist who brought “the family, the nurses, the SF [Supporting Families], everybody in the one room. [We all] knew what everybody else was doing and the client was happy with that” (Team Leader 2, Focus Group P, Hamilton).

Establishing legitimacy and credibility was central to the struggle between the different worlds of knowledge and experience. In the next section I explore the nature of training, professional development and what constituted up-skilling available to participants.

Credibility, *up*-skilling and training

Many participants spoke of clinical training as *up*-skilling and used other, similar metaphors to suggest that they naturalised clinical knowledge as more authoritative: A superior rather than merely different, kind of expertise. Clinical expertise was also seen as providing credibility and clinical credentials conferred authoritative status. A senior manager from Hamilton rationalised the stance of his organisation in employing clinically trained staff. He said, “The medical model for us, and our service, offers us some, [. . .] credibility in the field that we work in, and a lot of that has to do with those certificates that are sitting on [the] wall there”. However he also qualified this position, adding that the organisation “sees that as a good investment, but they don’t dominate how [we work]” (Senior Manager 2, Hamilton).

Recovery training was a key theme in many focus groups for how values and principles were communicated throughout their organisations. However, this was contrasted with other forms of mandatory training, with some

participants commenting that some training seemed in conflict with a recovery orientation. For example, one support worker from Hamilton remarked that “non-violent intervention to me doesn’t say anything about recovery” (Support Worker 5, Focus Group H, Hamilton) and another, team leader, remarked that “professional training compartmentalises people’s recovery” (Team Leader 6, Focus Group A, Hamilton). Others believed that, “Educating the professionals, like the psychologists, is the big one. There are some really open ones but there are some that are just very old school” (Peer Support Worker 4, Focus Group PS, Auckland).

These comments suggested that, for participants, other kinds of knowledge and expertise were required to support people effectively in services, and that this “other” knowledge was difficult to introduce and establish. They reported that other forms of knowledge and expertise such as subjective experience or alternative therapeutic models were typically discredited or dismissed. Participants seemed to think that most clinicians were not willing to expand their knowledge base or acknowledge other discourses, even as adjuncts to the medical model. One peer support worker exclaimed, “Yes the medical side of it is relevant [but] they have worked their whole career and whole lives in the mind-set of a medical model, they are not willing to open their minds up to something that is completely different” (Peer Support Worker 8, Focus Group PS, Auckland).

In contrast, most participants found value in being able to draw from multiple sources of knowledge and experience. One Christchurch participant remarked, “They need to put both together to work well. Just because I haven’t got the letters behind my name [or] just because I am a consumer - and yes mental health consumer- doesn’t mean that I haven’t got some good things to say” (Peer Support Worker 2, Focus Group S, Christchurch). There were many similar accounts and participants certainly did not want to discard knowledge; they just wanted a more wide-ranging and inclusive set of responses to be available. As a team leader from a service user organisation in Hamilton said,

“There is definitely massive value in both. Put them all together in some sort of healthy way” (Team Leader 1, Focus Group A, Hamilton).

Professionalism and expertise, therefore, acted as much to exclude other kinds of expertise as they did to protect biomedical knowledge within strongly demarcated professional boundaries. Being forever outside these boundaries, mental health support workers and NGOs were routinely discredited and devalued. In addition, the reproduction of institutional power was clearly constituted, at least in part, through the longstanding assumption of medical responsibility for the well-being of society, and how this has been embedded in the regulatory environment. Maguire and Hardy (2009) referred to this as the legislative pillar of institutions.

Legitimation and authority: The legislative pillar and relationships of power

The legislative environment, historically, has been particularly influential in mental health care with a longstanding and state sanctioned relationship between psychiatric medicine and the criminal justice system. The evidence, however, suggested that the institutions have over-stated this responsibility, drawing on a variety of arguments about societal expectations and mutual interests in managing “the public good”. The Mental Health Advocacy Coalition (2008), maintained that while mental health services have a “politically charged role of containing and controlling some people. It’s easy for these services to lose their focus on the needs and views of people who use them” (p. 26)

Senior Managers tended to articulate a more global and strategic awareness and understanding of how their organisations were positioned within the larger regulatory frame. Several, especially those in Auckland where collaboration was possible over five DHB regions due to economies of scale, were undertaking organisational initiatives to increase their own legitimacy and credibility. However, it was apparent that this was as much about organisational sustainability and survival as it was about organisational transformation and the

realisation of their best intentions. A considerable degree of compromise was evident and this was inevitably on the part of the NGOs.

Degrees of compulsion: “Being under the Act” and other mechanisms of control

The Mental Health Act (Ministry of Health, 1992), as noted earlier, was an attempt to balance the human rights and needs of individuals with the wider interests of the general community. It conferred considerable responsibility on clinicians for the safety of “the community” as well as the authority to compulsorily treat and contain people it deemed a threat. However, in practice, people have found it increasingly difficult to access mental health services on their own terms; instead being left until they have full blown crises which has then made it more likely they would be compulsorily admitted “under the Act”.

Clinical power and control was often rationalised under the guise of clinical responsibility for the safety of individuals and communities. National texts and the dominant biomedical stories about mental health services generally ignored coercion and compulsion as underlying features of many relationships between service users and clinical staff. Yet these remained highly significant for service users and participants frequently referred to abuses of power. In addition, it was clear that treatment continued to be used as threat or punishment, despite such practices being widely criticised over decades through public inquiries (W. Brunton, 2005; Mason, 1988, 1996), the media (Marbrook, 2012) as well as various investigative reports (Mental Health Commission, 2004) and even, recently, acknowledged by the Ministry of Health (Ministry of Health, 2012). A peer support worker from Auckland described the powerlessness that people experienced saying, “I have seen it happen where a young guy got angry at his case manager; he was angry. That case manager went ‘Right, put him in hospital.’” (Peer Support Worker 3, Focus Group S, Christchurch).

These situations were also indicative of the privileged status of clinical specialists and policy analysts who staff the Directorate of Mental Health (Ministry of Health, 2011) and are key informants to national policy and strategy

texts. This kind of institutionalised power has been at the expense of other stakeholder perspectives such as the NGOs, which have been increasingly invisible in such texts over the last 15 years (Mental Health Commission, 1998a, 2004b, 2007a, 2007b, 2012a, 2012b; Ministry of Health, 2005, 2006, 2012c).

In addition, the establishment of the District Health Boards in 2000 blurred the boundaries for most participants between their funding and contracting responsibilities with simultaneously being the providers of clinical services in their regions. Clinical staff from the DHBs regularly assumed extra authority over staff from the community organisations; although it was the funding arms that were responsible for contracting arrangements with NGOs. Participants seemed to accept this without understanding the distinction. A support worker from Hamilton commented, “Ultimately we are in there because of the DHB: ‘We contract you blah, blah, blah, we are technically directly responsible.’ [So] whether you like it or not [they] are the boss man” (Support Worker 1, Focus Group H, Hamilton).

In addition, participants from all regions reported clinical staff blurring the boundary between legislative authority and coercion; in effect overstating the limits of their responsibilities to service users. One service manager compared his own youthful experience with what happened to service users in mental health services:

There is an automatic assumption that we have to take the power and control off them. Nonsense. It is the first time he has ever got power and control. I can remember my first pay cheque - well probably my first 50 pay cheques, you know - I am going to drink, I am going to smoke, I am going to have fun. Because that is what happens when you give them their

money back, they party. [. . .] But there is a lot of pressure to put him under 3PR²¹. (Senior Manager 3, Auckland)

Many participants expressed concern at the very real consequences of “non-compliance” for service users under this authority. Ultimately, perceptions of compulsion seemed antithetical to the sense of hopefulness that underpinned most participant discourses of recovery. They also reported the immense frustration and powerlessness service users experienced through being ignored. A senior manager from Christchurch told a story of a young man’s fear, humiliation and “his outrage at being put under the Mental Health Act because he didn’t comply, and his fear, real fear of the permanent repercussions for his life. He is 20” (Senior Manager 1, Christchurch). She went on to explain that the issue was his refusal to take a drug because of the pain it caused him. She said, “20 year olds aren’t used to being constipated; it is as simple as that. It is a very personal, intimate area in which he just doesn’t want to have strangers involved. [They] are not really acknowledging that this is not just a physical condition; this is also an emotional response to the circumstances he is in” (Senior Manager 1, Christchurch).

Participants were in no doubt that these instances were primarily about control rather than any therapeutic benefit. Several talked about “key workers that are holding back [service users and they] have to go to them for approval for everything that they do” (Support Worker 5, Focus Group H, Hamilton) This was particularly frustrating for participants who recognised that other ways of working with people were more effective and congruent with the self-determining aspirations of recovery. Many participants, and especially those with their own experiences of distress, were insistent that feeling in charge of

²¹ The 3PR Act allows the Family Court to make orders for people who have lost their mental capacity. The court can make ‘personal orders’ to deal with a specific issue or it can appoint a welfare guardian to have a general power to look after someone's personal care. (Protection of Personal and Property Rights Act 1988,)

one's own life decisions was critical to recovery. A peer support worker from Auckland observed, "Our clients don't get to make their own decisions about their own lives which is really horrible because the empowerment of being able to make your own decisions is like control" (Peer Support Worker 2 Auckland).

This reinforced the perspective expressed by many participants that heavy-handed use of statutory power was unnecessary and ineffectual. Instead, they averred that patience, time, and positive relationships with service users were ultimately more effective and beneficial ways of working. As one team leader remarked, "The majority of the time [we] can talk them around and not require the hospitalisation but it's been the service or [a particular] clinician working in that way and being prepared to just take a little bit more time, whereas not everybody does". She went on to describe "the punitive approach" as "if you don't do that we will put you into hospital" (Team Leader 3, Focus Group A, Christchurch). However, some psychiatrists seemed willing to expand the boundaries of their professional relationships with service users and work with greater degrees of freedom and self-determination. Unfortunately, this seemed restricted to particular regions and individual clinicians who "have tried to just keep the relationship intact for a period of time; so not force medication" (Team Leader 2, Focus Group A, Hamilton) rather than systemic policy and practice.

Participants generally perceived that, whether subject to legal compulsion or other forms of coercion, service users were routinely, and regularly, "told what to do" rather than being asked, "What can we do for you to help you?" (Team Leader 1, Focus Group A, Hamilton). It was evident that clinical staff used authority over service users and there were serious consequences for non-compliance. In the next section, I look more closely at issues regarding who controlled access to services with a particular focus on "gate-keeping" as indicative of continuing institutional power.

Access, exit and “gate-keeping”: The significance of referral processes

Procedures for access to mental health services have been widely acknowledged as being of concern (Ministry of Health, 2011) and it was clear from participant talk that decision making was still very much in the hands of clinical professionals, and this was reinforced systematically. In particular, clinical services were the “keepers of the gate” to the whole spectrum of services and controlled all access, referrals and exits. It was also evident that the NGOs were similarly powerless to initiate action. A team leader from Hamilton expressed her frustration when alerting the community mental health team to an early warning sign and asking, for example, “Would you pop in and do the second visit of the week tomorrow rather than Friday?” Then she subsequently found that they did not visit because the “person didn’t open the door.” As she exclaimed, “Well that should be telling you something!” (Team Leader 2, Focus Group A, Hamilton)

In contrast, gate-keeping access to mental health services created several issues for people wanting early intervention and support. Relinquishing control was a perceived barrier for some people, who would rather forgo help than risk being caught up in the mental health system. Peer support workers in Auckland explained how counterproductive it could be for people wanting to access their service, but having to go through DHB clinical services to do so. As one said,

It doesn’t make sense because our role is to catch them when they are still motivated to do goals and things like that. But then they have to do the battle of getting into the mental health system to actually access us which is awful.

(Peer Support Worker 2, Focus Group A, Auckland).

Furthermore, even access to the NGOs was governed by referrals from DHB clinical teams, and could set up unwelcome competition among community providers. This situation could be exacerbated by personalities and individual preferences that impacted on the reputation and credibility of the NGOs. A group from one Hamilton organisation discussed how referrals could depend on the perceived reputation of the organisation “or the trend or favour of [clinical

staff], like, you know, who is the flavour of the month type thing” (Team Leader 1, Focus Group H, Hamilton). Similarly, it seemed clinical key workers were somewhat laissez-faire; content to let NGOs lobby for referrals and comfortable with the respective roles of power this reinforced. These scenarios were at odds with descriptions of the non-government sector as crucial to the delivery of mental health and addiction services (Ministry of Health, 2012; Peters, 2010).

Alarming, the opposite could also be true, and referrals could happen without even the service user being informed. It was also apparent that discharge plans and referrals were routinely developed independently of the NGOs and families, and in the worst cases, people were discharged to services or families without any foreknowledge or communication. This created tensions and negative impacts for all those involved and flew in the face of notions of “person centred” recovery. A team leader from Hamilton shared her experience of, “The person doesn't actually know they've been referred to me. So *their* choice? They're wondering why the hell I've turned up on their doorstep” (Team Leader 2, Focus Group W, Waikato). Unfortunately, this was not a rare occurrence and reflected an administrative imperative rather than a recovery-focussed decision. Another example from a different Hamilton focus group noted that, frequently, “We get the ward ringing us saying, ‘So and so is going home. The family don't want him, he is leaving today’ and it is too dangerous” (Team Leader 5, Focus Group A, Hamilton).

At the other end, as discussed previously, people were also “exited” or pushed towards exit on the determination of DHB clinicians or funders alone. Some were cut adrift because they no longer fit criteria determined by DHB funders. A support worker from Christchurch explained that she “had to discharge two clients because funding was no longer available to them under the magical age of 65, [and] the choice had been taken away from them” (Support Worker 1, Focus Group S, Christchurch)

It was evident, therefore that in accessing the mental health system people were frequently, and systematically, disempowered. It was difficult to consider recovery in this context despite most participants recognising that

service users being included in the decision making processes that most affected their lives was integral to successful outcomes. In the next section, I address some of the processes embedded within mental health services that served to ensure compliance and, therefore, maintained institutional power.

Asymmetry and dependence: Funding, contracting & the costs of “non-compliance”

Institutions are characterised by their capacity to create resource dependencies and political vulnerabilities among organisations that may have conflicting goals and interests. The community NGOs were in such asymmetrical relationships of dependence with the DHBs. The conformity of the community organisations was established and maintained through extremely high costs for non-compliance with institutional pressures. For NGOs, non-compliance carried economic risks; not only directly in terms of funding, but also in terms of reduced legitimacy and access to the resources that come with legitimacy (Phillips et al., 2004). Organisational viability clearly depended on keeping both clinical and contracting teams happy. Many participants referred to “the power that the DHB has to be able to pull funding if you don’t play the game as an NGO” (Team Leader 2, Focus Group A, Hamilton)

Increasing managerialism exacerbated tensions for the community mental health organisations, which had little input into developing contracting and service specifications. However, as noted in a report commissioned by *Platform Trust* (2008), the blurred boundary between the provider and purchaser in DHBs meant that “provider-arm health professionals and managers are influencing funding and planning processes” (p. 5) clearly to the disadvantage of NGOs. Many focus group participants did not realise that clinical teams do not actually contract their organisations but, rather, both are providers of, what should be, complementary services. This sense was reinforced by clinical key workers who assumed authority over support workers, based on their own perception of unilateral DHB power, and under the guise of clinical responsibility. This asymmetry in their relationships was naturalised by some participants and masked its institutional power. “It isn’t about power; put that on the shelf. It is

about responsibility” one Hamilton support worker protested (Support Worker 2, Focus Group H, Hamilton).

The *Platform Trust* (2008) report, also noted a general lack of transparency in contracting processes and highlighted that DHBs had received overall gains in funding but were failing to pass these on; thus expecting the NGOs to provide the same services, but leaving them seriously and systematically under-funded. For example, one senior manager from Wellington remarked that “We have no FFT (*Future Funding Track*) and no cost of living adjustment; they have kept it all” (Senior Manager 3, Wellington). Another senior manager from Auckland described their contractual obligations as having “to ensure that things are done certain ways, and that doesn’t always fit with the ideal; with what an ideal kind of recovery approach would be” (Senior Manager 4, Wellington). In some cases the time-frames for contracts were arbitrarily adjusted, down to three months in one example, meaning that strategic planning and forecasting around staffing needs etc. were nearly impossible. Other participants reported hostile audits that ignored positive evaluations and services that were cut despite evidential success. In general, satisfying conflicting stakeholder interests illuminated power differentials in which the NGO services always seemed to be the “losers”.

Wariness about unbridled managerialism and potentially punitive environments, also meant that organisations appeared to be over-emphasising administrative and reporting tasks at the expense of interpersonal support work. Many participants made reference to tasks that were time consuming and fundamentally managerialist “risk aversion”; these were meeting organisational needs at the expense of service users wishes. A team leader from Wellington explained that they were often doing things “just to cover our butt” and this meant expecting support workers to “spend all their time recording everything, just to cover ourselves, for no positive reason, it is really hard to balance” (Team Leader 3, Focus Group A, Wellington). Other managerialist requirements, including audit processes also appeared to have resulted in ponderous and top-heavy infrastructures. No participants referred to these as improving practices

or service delivery; instead, they discussed at length how these requirements interfered with their daily work lives. A group of Wellington support workers discussed such requirements as irrelevant at best and “just auditors’ requirements to get their tick boxes so that their managers [are] covering themselves” (Support Worker 6, Focus Group A, Wellington)

Changes in personnel within the DHB could also lead to radical and arbitrary changes in policy to which the NGOs were particularly vulnerable, and which ran counter to their own ideals of recovery-oriented service delivery. Even a strongly articulated and coherent alternative discourse within an organisation was no protection from more powerful institutional directives. At a service delivery level, these influences were apparent in contracting requirements for goal planning in particular. One group of senior managers believed that the environment was now so bad they described how “the journey forward is transformed through the journey to nowhere, into the journey backwards” (Senior Manager 5, Wellington). In some regions, and in individual cases, relationships with institutional agents were changing. However, as I shall discuss in the next section, blurring the boundaries between power and responsibility could give the appearance of personal power and freedom of choice to service users, while actually maintaining institutional power under the guise of individual “responsibilities”.

Compliance, control and setting goals

As is clear from what has been presented this far, service users appeared to have very little control over what treatments or service responses they received. Participants reported serious limitations in the choices available to them and service users, exemplified by the compulsory development of individual goal plans. Many participants commented this process was antithetical to “client-centred” recovery and that needs assessments prioritised the expectations of the referrer and a service user’s own choices and aspirations were ignored when these were in conflict. These priorities also meant that goal planning typically focused on functional rehabilitation measures rather than recovery outcomes indicative of meaningful and satisfying lives in the natural

community. As one Wellington participant remarked, “When a client gets referred there will be a list of goals, usually around medication, personal hygiene [and] diet” (Team Leader 5, Focus Group B, Wellington).

Participants routinely reported that these plans were developed by clinical staff and frequently contradicted what service users said they wanted. In contrast, the preferences they identified required approval by DHB clinical key workers. They were often frustrated with key workers who set nominal goals for service users and implicitly for support workers as well. A team leader from Waikato complained that key workers would claim, “A person needs friendship and companionship and things like that, and expect us to provide them”. She went on to explain that she and her organisation were more interested “to talk about developing relationships as a goal; not having a support worker become a friend” (Team Leader 4, Focus Group W, Waikato). Similarly, a senior manager from Auckland contrasted personal aspirations with arbitrary, functional goals such as, “You need to have five friends, and you need to have a job for 20 hours” (Senior Manager 1, Auckland).

Managing conflicting interests created an extra layer of complexity for the community organisations and support worker. One senior manager described it as “tricky” when plans were not “what people have said they want, but what important people have said is important” (Senior Manager 1, Auckland). These plans also reflected the values of workers or organisations and several participants drew on a language of permission, for example using phrases such as, “letting them” and “allowing”, with one team leader going so far as to say “even I know you [service user] can do it and *I expect* you to do it.” (Team Leader 2, Focus Group W, Waikato, *emphasis added*). Others used a kind of royal “we”, to disguise the locus of authority. For example, “*We* have got a plan about maybe keeping the flat clean for the next three weeks” (Team Leader 1, Focus Group W, Waikato, *emphasis added*) or “[We] as a team might say this person *needs* to” (Support Worker 9, Focus Group A, Wellington).

Participants who used such constructions seemed somewhat unreflective and did not seem to consider that service users might be resisting a sense of

disempowerment about the lack of choice in managing their own lives. For instance, this team leader couldn't understand that after trying to teach someone "every day for six months [to] clean the toilet", and "they still haven't got it!" (Team Leader 6, Focus Group P, Hamilton). Other participants offered more thoughtful responses that acknowledged an ethic of being honest about organisational imperatives that worked against people's autonomous choice. A senior manager from Auckland admitted that, "The reality is that sometimes it is our goal and sometimes it is stuff that we have been told we have to do. [. . .] So we try to be honest with that" (Senior Manager 4, Auckland).

Several participants also noted that goal setting was often expected to be an unrealistically "quick fix" after years of distress and social marginalisation. A team leader from Hamilton commented on the "misunderstanding about whose recovery it was" and the unrealistic timeframe "when it has taken a lifetime getting to a certain point and then a five minute fix up job is expected" (Team Leader 1, Focus Group A, Hamilton). Many talked about how it takes time for people to know what they want and that frequently they had been removed from opportunities and resources for so long that they needed graduated exposure to new possibilities and a sense of a larger world. One senior manager was insistent that it was necessary to first notice what a person likes, or has enjoyed in the past and be persistent. He said, "Expose them to it, [and] don't do it once because we never like anything once, unless it is amazing. [They need to] do it several times" (Senior Manager 3, Auckland).

Others, too, argued for a more subjective and responsive approach to measuring progress towards goals and recovery. Many expressed frustration that the person's own life choices and measures of success were ignored or dismissed. In a discussion about what counts as progress, a team leader from Christchurch commented that, "The person themselves thinks, and their family thinks how far have they come, no hospitalisation in three years, and all those things that I think are so overlooked sometimes" (Team Leader 3, Focus Group A, Christchurch). In addition, maintaining a recovery orientation that was attentive to a person's strengths, resourcefulness and aspirations was clearly subordinate

to other, typically DHB contracting, objectives. A senior manager from Auckland admitted that working with strengths was not “part of our formalised practice but [is] something that we build into review processes” (Senior Manager 1, Auckland). Unfortunately, such a procedure offered few opportunities for self-determination despite the discourses of “client-centred” services.

Participants generally thought that goal planning was another mechanism by which clinical services established and maintained control over service users and the organisational practices of the NGOs. However, the tensions also appeared to be somewhat naturalised and legitimised by institutional constructions of clinical and managerial “responsibility”. This translation of institutional power seemed to close down further discussion of the nature and role of goals in supporting a person’s aspiration to live well in their community.

Conclusion

Institutions become established, discursively, as socially legitimate largely through the power and longevity of their historical traditions, relationships and norms (Lok & Willmott, 2006; Phillips et al., 2004). They persist because they become naturalised by communities and societies, who also devolve a great deal of responsibility and authority to institutional agents. The normative, cognitive and legislative features of institutional entrenchment were all apparent in participant talk, and this clearly had serious implications for the establishment of an alternative, recovery paradigm in mental health services.

In particular, it was clear that recovery discourses had not been effective in deinstitutionalising biomedical and managerial norms despite the adoption of recovery language in organisational and national texts. Participants reported that recovery approaches were routinely overridden by clinical and managerial imperatives and it was apparent that the institutions have continued to govern organisational communication and practice throughout the sector. In fact, constructions of deinstitutionalisation, in other words treating the institutions as features of the past, effectively created discursive closure around both

biomedicine and managerialism as powerful, institutional drivers of organisations in the present.

Normative power was particularly evident in the naturalised assumptions and hegemonic conventions underpinning participant attitudes to mental “illness”, community care, and other important concepts. This explained, perhaps, why participants made ubiquitous, incidental references to biomedical and managerial power in organisational life and yet did not appear fully to understand their complex structural and discursive institutional features. This meant that participants tended to express their many frustrations and issues as local and idiosyncratic rather than systemic and institutional.

The cognitive institutional pillar was evident in the social and political legitimisation of biomedical power that mandated clinical, professional authority over the care, control and cure of “mental illness”. The clinical story of people’s experience was at the heart of the institutional medical model and frequently separated people from a sense of ownership over their experiences as well as ignoring their own explanatory models. Many participants reported that while diagnosis could be useful, service users generally experienced it as unhelpful and intransigent. It also appeared to lead to the unreflective pathologising of ordinary human emotions and common life circumstances. In addition, the narrow lens meant a limited range of treatment options, which were controlled by DHB clinical services and funders, further limited the power and choice of service users and the community organisations.

Operating from the same functionalist rationality biomedicine and managerialism worked in conjunction, through the DHBs, to determine the nature of treatment, service responses, and the ways that outcomes were measured. Social valorisation of clinical authority meant that professionals also claimed expertise in defining and translating recovery for participants and other stakeholders. These institutionalised translations inevitably pervaded the community NGOs as well, and effectively controlled organisational discourse and practices.

Legislative power and the regulatory authority conferred on the institutions created relationships of resource dependency and vulnerability among service users and mental health workers, as well as between NGOs and DHB services and funding arms. While many participants, and even sector policy documents, talked about personal power and responsibility in recovery, considerable tension was evident in the exercise of control over significant decisions in people's lives. In particular it seemed that both funder and provider arms of DHBs exploited the boundaries between institutional power and clinical "responsibility" and this created asymmetrical relationships between clinical services, community support staff and service users.

Asymmetrical and resource dependent relationships among the community sector and DHB funders and clinical teams meant that the costs for *non-compliance*, in terms of both funding and referrals, posed serious risks to the viability of NGOs. Participants linked discussions of these relationships to organisational decisions about the focus of service delivery; specifically service specifications and reporting requirements that were frequently at the expense of the personal autonomy of service users. While there were some, regional, examples where effective relationships, even collaboration, had been established among clinical, support staff and service users this was clearly not systemic; relying instead on the individual approach of some clinicians and the persistence and energy of the NGOs.

It was very clear that institutional dynamics continued to construct, constrain or contradict organisational practices in terms of becoming recovery-oriented despite a naturalised assumption of deinstitutionalisation in the mental health sector. In the next chapter, I examine the ways in which these circumstances were problematised by participants and by the voices of service users through emerging narrative accounts in significant national texts. There I not only analyse the evidence for the effectiveness of disrupting institutional power but also the ways in which the institutions could be seen to counter challenges to their power and status quo.

Chapter 8: Fighting back: Struggles, challenges and innovation

Our intentions are good; our actions must be even better, and our achievements will be outstanding. (Turia, 1999).

Introduction

In the previous chapter, I established that the institutions of biomedicine and managerialism have continued to direct organisational discourse and practices in the mental health sector. The findings provided evidence of the persistence of institutional power through the structural framework of the normative, cognitive and legislative institutional pillars. It was also apparent that participant references to biomedical and managerial influences in the community NGO sector were generally negative. This was noteworthy because the focus group questions were not explicitly directed at the institutions; in fact, my use of an appreciative inquiry methodology anticipated and encouraged narratives of what was working well, and successful outcomes, in these organisations. It was clear, therefore, that participants as well as authors of important texts, challenged, problematised and resisted systemic institutional power in various ways. These challenges and counter challenges further illustrated the problematics of voice and organising in mental health services.

Assumptions of professional benevolence, expertise, legitimated coercion and what it meant to be a mental health service user were all contested territories. In addition, it was clear that alternative paradigms and discourses such as recovery had not achieved social or political legitimacy, and this was largely due to institutional pressures. In this chapter, therefore, I address my third research question: In what ways are institutional dynamics being problematised and challenged within the community NGOs and to what effect?

I first examine how participants and texts problematised and resisted institutional power through localised insubordination as well as more coordinated efforts and activism. Second I examine change efforts in the sector,

from both *inside* and *outside* the institutional frameworks, and investigate how effective these have been and under what circumstances. I explore evidence of some of the attempts made by the NGOs, as institutional outsiders, to establish innovative, alternative service delivery models as well as their struggles for organisational transformation in the sector. I discuss how effective these initiatives appear to have been in disrupting institutional dynamics.

I then attend to the ways that the mental health institutions, through the DHBs, undertook defensive institutional work in the face of challenges and perceived threats to their authority. As previously discussed (p. 136), an important, although not rigid, distinction can be made between generalised and particularised defensive institutional work. Generalised, primarily discursive, defensive work was explored in Chapter 7. Therefore, in this section, I draw on the data to discern the strategies that institutional agents utilised, not merely to preserve the status quo and restore stability, but to purposively contain change efforts and counter perceived threats to their authority and status. It was evident from sector texts and participants' reports that counter-challenges were impeding the establishment of recovery as an orienting basis for discourse and practice in these community organisations.

Subordination and insubordination: Taking on the institutions

Initial analysis indicated participants resisted both biomedical and managerial authority using a variety of strategies. Their frustrations were exemplified by the subordinate roles that most were ascribed by the clinical and funding arms of the DHBs. Insubordination was evident in their explicit attempts to problematise institutional dynamics as well as more organised attempts to challenge and disrupt institutional pressures. These efforts ranged from local and situated instances of "getting sneaky", to more proactive attempts at advocacy and activism. These tactics had variable efficacy in undermining institutional pillars.

Subordination and control: Problematising the system

Despite seeming to have a limited awareness of the assumptions and frameworks that underpinned institutional persistence and strength, participants problematised the mental health system as a whole and particularly the hierarchy of inter-organisational relationships that positioned support workers and NGOs as subordinate to clinical staff. Many made references to “mental health” and “the system” as overarching constructs with one describing it as a “juggernaut” and a “king unto its own” (Senior Manager 2, Hamilton). Yet the national mental health and addiction plan (Ministry of Health, 2005, 2006), among others, claimed that mental health services were already based on “a strong consumer voice and a recognition that services must be built around the needs of the people who use them” (p. 2). Such statements were ambiguous in terms of who had the authority to determine a person’s “needs” and this meant that hierarchical relationships of authority remained unchecked.

The use of *person centred* and *outcome focussed* service descriptors was ubiquitous and commonly used in organisational and national texts (Ministry of Health, 2005, 2007; MHAC, 2008 *among others*). The Mental Health Commission (2007), for example, explicitly addressed the need to reduce inequities for service users, stating that, “Autonomy will [be] reflected by people working to minimise power imbalances, regardless of their role” (p. 23). However, not only did these texts fail to define how expectations of “consumer voice” might actually be embedded in service delivery and development but participants, too, resented their lack of an effective voice in the ways that service specifications were developed.

Participants explicitly problematised a “system” that seemed intent on following an agenda that perpetuated practices of limited efficacy and ignored the expressed needs and wants of those affected most by such service provision. A team leader from Waikato described what he saw as service users “stating clearly that, ‘This isn’t actually working for me.’ But nobody seems to be listening” (Team Leader 5, Focus Group P, Waikato). Another participant, a senior manager from Christchurch, remarked, for example, that the clinical needs

assessment process “covers very much that deficit dysfunctional model thing, and these are not usually what someone would say their needs are today, tomorrow, next week, and definitely not the things that are going to motivate them to make changes” (Senior Manager 2, Christchurch). Others expressed frustration at an over-riding sense that “nothing changes” (Senior Manager 4, Wellington).

The perception of the system as immovable and intransigent was reinforced continuously, yet few articulated their frustrations as symptomatic of systemic, institutional power. Even where there was a realisation that issues were systemic, there was an overall sense of powerlessness to effect change, whether as individuals or organisations. This team leader from Hamilton argued that:

You see everything going round and round in circles. If you don't stick something in the middle to stop it, they're just going to carry on [for] year after year after year after year, and [you] think 'Goodness, why didn't someone change something.' I don't really care [what]; just try something different, but no one does. They just keep doing the same thing. (Team Leader 2, Focus Group A, Hamilton)

As well as being contrary to recovery principles and aspirations, many complained about an inefficient use of resources, the bulk of which have continued to go to clinical services despite “people living most of their lives in the community” (Senior Manager 1, Hamilton). Participants were especially exasperated by the inefficiencies of the revolving door syndrome. One team leader reported that, “By the time [the] process goes through they have discharged themselves and gone back to wherever they came from, only to go full circle back to [the inpatient ward], so we get the same assessment process happening six months later” (Team Leader 3, Focus Group P, Hamilton).

Participants were also angered by the way that service users' behaviour became institutionalised with most obediently “doing what they're told” by professionals (Senior Manager 2, Christchurch). A team leader from Hamilton

stated that, “So many people will just swallow their pills - and they don’t know what they are for. [Just] because they have been told to, and I hate that” (Team Leader 1, Focus Group P, Hamilton). Others noted that “compliance” was often due to anxiety about their interactions with professionals and there were many comments such as, “They’re frightened of doctors. The doctors don’t explain properly; they just say “You need this sort of pill, away you go” (Team Leader 1, Focus Group A, Hamilton). Negative interactions and coercion were recurrent themes in the focus groups particularly. Many considered the system itself to be harmful to service users and their aspirations for recovery, with several remarking that hospitalisation was typically a negative experience and people then had to recover from “being in that kind of environment” (Senior Manager 5, Wellington).

Additionally, most participants were concerned about the lack of real choices and the inequity of service users’ relationships with clinical staff. It seemed that, while service users were routinely ascribed individual responsibility, for their lives and well-being, this did not equate to personal power or self-determination. This also meant that a client’s “responsibility” frequently translated into a client’s “fault” and one team leader observed, “It’s really scary because it is always the client’s fault, their problem” (Team Leader 2, Focus Group B, Auckland). The inherent power imbalance was evident in everyday encounters and several participants reported service users having to seek “approval for everything that they do” (Support Worker 2, Focus Group H, Hamilton) from clinical staff.

It was not hard to understand the reasons for mistrust when clinical power often seemed inappropriately used. The Code of Consumer Rights (Health & Disability Commission, 1999), for example, includes, among other protections, the rights of service users to see any information held about them, yet this was regularly over-ruled. In several cases, participants commented that service users were not “allowed to see their own notes because that might upset them and [make] them unwell” but, as he added, “If you saw some of the things that people write then you would be upset too” (Peer Support Worker 7, Focus Group

PS, Auckland). Even where service users were able to articulate their wants and tried to self-advocate, participants reported that decision making was seldom collaborative and another peer support worker from Auckland remarked that she “had to go along with all the medication for them to [approve the treatment I asked for]” (Peer Support Worker 2, Focus Group PS, Auckland).

Participants frequently, and unfavourably, compared their organisational environments and practices with in-patient services. The overall impression of the hospital environment was of stressed staff working within restrictive institutionalised environments and ignoring the common sense basics of a person’s life and needs, and in the process dehumanising and humiliating them. A team leader described her visits with a client who had been admitted to in-patient services. She said, “He didn’t know where his shoes were; didn’t know where his clothes were; didn’t know where his wallet was. [. . .] I had seen him bare feet one week and I still see him bare feet the next week” (Team Leader 5, Focus Group P, Hamilton)

Participants noted a systemic lack of accountability by the DHBs and discussed how clinical services frequently worked to ignore or conceal bad practice. One senior manager recognised this as a systemic, institutional issue. She said, “There is a culture there that is very risk averse about doing performance management . . . Clinical staff can fly under the radar for years, and they can be [left] unchallenged around the quality [of their work]” (Senior Manager 4, Auckland). Others were similarly conscious of the difficulties in shifting the institutional culture, especially the cost-benefit argument that ignored where most mental health funding was spent. A senior manager in Christchurch compared the NGO staff, who were paid a lot less but were willing to “work with somebody for years” if necessary, with the “\$1000 a day hospitals [where] recovery doesn’t work as well”. She added that DHB funders seemed to have “just acknowledged that as a culture that is very difficult to change” (Senior Manager 1, Christchurch). These situations were reinforced by other, managerial priorities that also impacted negatively on recovery outcomes as participants constructed them.

Sector relationships were clearly a systemic, institutional and inter-organisational issue and not merely an interpersonal one. The vulnerability of NGOs to the effects of personnel changes within DHB funding and planning portfolio holders caused much apprehension about whether “the system [will] survive when the person moves on” (Senior Manager 3, Auckland). The same senior manager echoed others from around the country that were concerned that the system was “pretty much personality driven” (Senior Manager 2, Wellington). Participants expressed concerns about personality politics repeatedly. Another senior manager commented, “I find the funder quite easy to talk to. I can talk to her about all these wonderful things we want; she thinks it is fabulous; but you know it won’t go any further than that” (Senior Manager 3, Hamilton). This created serious uncertainty for long-term service development (Peters, 2010) and genuine change was not apparent despite policy and, in some cases, good relationships with funders.

In the next section, I discuss how participants, and texts that advocated for the role of NGOs, were critical of an increasingly managerialist environment that dictated their organisational practices, supported biomedical authority and constrained the emergence of alternative paradigms.

Problematising managerialism and the contracting environment

Managerialism was as much an embedded feature of the institutional *system* as biomedicine and, as discussed in the previous chapter, participants regularly conflated the clinical and funding arms in referring generically to “the DHBs”. Most participants, and especially the senior managers, referred to the contracting environment and their contracting relationship with DHBs as the greatest challenge to organisational survival. Substantial regional variations were evident, which added to a sense of *ad hoc* policy and planning within DHBs that impacted negatively on the community organisations’ ability to plan and their long term viability.

The *Platform Trust* report (2008) noted while “there are pockets of excellence characterised by consistent and knowledgeable funding and planning

managers” overwhelmingly the picture was characterised by “high turnover, lack of experience, and concern that the loss of institutional knowledge about the nature and purpose of contracts makes NGOs extremely vulnerable” (p. 5). Jan Dowland, the chair of *Platform Trust*, concluded that the contracting environment painted “a disturbing picture” where “the dictates of the system have dominated the discussions between DHBs and NGOs, rather than how to improve the lives of people” (*Platform Trust*, 2008, p. 4). Similarly, participants in this research, were also frustrated with cumbersome reporting and audit requirements, unilateral decision making within DHBs and delays in negotiating contracts. Most were concerned that meeting contracting requirements meant taking time away from the *real* work and recovery.

Many were also critical of contracting and funding processes that increased their vulnerability and subordination to the DHBs; but which also reduced their organisational capacity for flexibility and responsiveness. Most were frustrated that there was no real accountability around values and recovery in an environment where anyone could “say what they like; as long as the contracts keep rolling in” (Team Leader 5, Focus Group A, Christchurch). They were concerned that, in becoming contracted service providers, their organisations had moved away from their constitutional obligations and accountabilities, and created “a whole new set of rules and dilemmas” (Team Leader 4, Focus Group A, Hamilton). A senior manager from Christchurch worried that many flax root organisations had lost their identity when they “got themselves into contracts and that is a totally different spin on who and what you are. So I think there is a challenge for organisations to retain independent integrity and [there] is real tension there because often the funder does not want to buy what you want to provide” (Senior Manager 2, Christchurch). Overall, the burden of managerialist-driven procedures actively thwarted the attempts of these organisations to become recovery oriented.

Participants reported feeling ignored, devalued and discounted with no place in contract negotiations for issues they saw as important. Much of this frustration was due to contracts that bore little resemblance to the realities and

needs of communities or organisations. Team leaders and senior managers, in particular, were critical of the disparity between formal Ministry policy positions and their contracted service specifications. A senior manager from Auckland remarked, “Sometimes I feel like they are coming up with stuff that someone said to them at a cocktail party the night before” (Senior Manager 1, Auckland). A team leader from Christchurch spoke of having to send contracts back to the DHB because they were full of targets and “we don’t know where they have come from and what they are about, the contract makes very little sense” (Team Leader 3, Focus Group A, Christchurch).

Many participants were similarly frustrated that their organisation’s recovery goals, as well as constitutional values and priorities, were frequently in conflict with the “quasi-market approach” (Team Leader 3, Focus Group A, Christchurch) and the difficulties of managing conflicting agenda were evident. A team leader from Wellington reflected that, “We want to be giving the best we can to the client group, [and a] recovery, strengths-based approach. And I do believe that most [staff] want to do that. It is this other [business] agenda that becomes the stronger beast in the camp” (Team Leader 1, Focus Group B, Wellington).

Unfortunately, managerial influences were further normalised by the typical makeup of trust boards. One senior manager explained the inherent difficulties in “trying to explain our work to a board that has a strong business background, and [they] kind of look at me sideways” (Senior Manager 2, Christchurch). The typically bureaucratic structures of organisations also tended to subvert the intentions and values of recovery. For example, a team leader from Christchurch expressed her frustration in saying, “We have got a board, we have got the CEO, we have got god knows how many general managers. We have got regional managers, operational managers, service delivery managers and support workers” adding that a business model was not helpful “without an understanding of [what we are trying to achieve]” (Team Leader 4, Focus Group A, Christchurch).

Generally, there appeared to be little institutional will, or structures, to treat NGOs as part of, let alone valuable to, the mental health sector. In the section that follows, I examine the ways in which participants resisted and challenged institutional authority while noting that their power to effect significant change was limited.

“Getting sneaky” and “being naughty”: Insubordination

As noted earlier, participants referred to inter-organisational relationships that positioned support workers and NGOs as subordinate to clinical services. “Once again it is the highest in the pack isn’t it?” remarked one support worker from Hamilton (Support Worker 2, Focus Group H, Hamilton). A team leader from Christchurch expressed a similar sentiment, in observing that those who “work within that [medical] model perceive the NGO sector as being an inferior workforce” (Team Leader 3, Focus Group A, Christchurch). All participants observed that clinical staff discounted the perspectives of support workers and peer support workers despite their close relationships with service users. They also routinely dismissed the role of support workers, treating them as care-givers or domestic help with referrals stating, for example, that a person needs “help in the home, the place is a mess” and the clinical key worker saying “Yeah get in there and do your thing.” (Support Worker 4, Focus Group A, Hamilton). Having their role devalued was clearly frustrating and one support worker from Wellington advocated for a change of job title, “Call us recovery workers, recovery guidance; call us what we are and what we actually do. [That] makes us recovery experts” (Support Worker 2, Focus group A, Wellington).

But it was apparent that support workers and service users could also be *insubordinate* and participants utilised a variety of tactics to push back against institutional mechanisms of control where they perceived these to be antithetical to the principles and values of recovery. Several participants described situations where they defied contracting requirements and service expectations explicitly in favour of actions they believed aligned with their values and ideals of recovery. Some, including senior managers, described such

behaviours as “being naughty” (Senior Manager 4, Wellington) or “getting sneaky” (Support Worker 4, Focus Group P, Hamilton).

It was evident that opportunities for insubordination were limited and sometimes being a “squeaky wheel” was the only effective challenge. This team leader from Hamilton noted that,

The people, we find, who don't get pushed to move on as quickly are people with strong family and things like that; parents who are really very strongly vocal. These are the people who will march up and bang on doors at the DHB.

(Team Leader 1, Focus Group P, Hamilton).

Others opted for covert resistance adopting more of a “what they don't know won't hurt them” approach. For instance, one group of support workers discussed how they would “carry on doing what we are doing now, just don't tell them, just work the way you would always work” (Support Worker 2, Focus Group A, Wellington). Another group decided, “It doesn't actually matter whether the organisation runs alongside you or not, what matters is that you are going to do it anyway” (Team Leader 5, Focus Group A, Hamilton).

Participants also challenged the authority of the biomedical model. One team leader commented, “I ignore the medical model because it is all about deficits, and my work is working with strengths. I am accentuating the positives so I ignore it” (Team Leader 5, Focus Group A, Auckland). Another, who had worked in various mental health services, remarked that, in the NGO environment, “We used to just work around the medical model; pretend it didn't exist really” (Team Leader 2, Focus Group A, Hamilton). Similarly, a senior manager from Hamilton explained that the medical model still determined “the practices that we are expected to adhere to” and added that resisting these expectations has meant that his organisation has been labelled “cowboys” because “we tend to push past those limits” (Senior Manager 2, Hamilton).

Many participants, although dismissive of professional expertism, were limited in their capacity to ignore this in practice. Some reported that service

users often used silence as the only form of insubordination available to them in the face of experiences of disempowerment. A team leader from Hamilton related that, “If you sit there, ‘Oh I did this and this and this and I’m the expert’, they know that you are full of it. It’s a crock, you’re not going to get anyone’s respect; no one’s going to trust you; they’re not going to tell you their story” (Team Leader 1, Focus Group A, Hamilton). Other participants spoke about service users utilising any power they could to establish control in relationships. As this support worker from Hamilton recounted, “I’ve got one client who tells me to fuck off if I am too early. [If] I am before 12 o’clock I am not allowed to go in her home [and] that is fine, I have respected that” (Support Worker 6, Focus Group H, Hamilton).

Many participants endeavoured to distance themselves from clinical staff and break down constraints that interfered with maintaining authentic relationships with service users. A team leader from a kaupapa Māori service in Hamilton described the sense of release that service users at her residential site felt when weekend staff took over and “all that humbug’s out. That’s all it is. It’s all just jargon and humbug. [It’s] just to impress the weekday staff that have to mix and mingle with professionals” (Team Leader 3, Focus Group P, Hamilton). Other participants discussed localised forms of resistance such as “fighting back” with health professionals on an individual basis. But overall, it seemed evident that individual, or organisational, insubordination was largely ineffectual in effecting systemic change; although, it sometimes offered some local solutions to specific circumstances. More coordinated activities such as advocacy were apparent but these too seemed limited in efficacy.

Advocacy and activism

Organised resistance was most evident from organisations with strong service user participation or leadership. The CEO of a service user organisation in Hamilton referred to her organisation embracing “grassroots activism” (Senior Manager 4, Hamilton). However, it was also clear that opportunities for systematic strategies such as advocacy were limited because the costs for non-compliance, both financial and organisational legitimacy, were too high. Some,

however, believed that radical system transformation and organisational change were necessary. For example, as another senior manager claimed, “nothing in this sector is going to get better until somebody has got the courage to tip everything on its head. Because building new beds in hospitals is not going to make anything better”. She added that to make recovery a reality, “We need to put the funding into the community sector, and we need to start getting real” (Senior Manager 3, Hamilton).

Other participants thought that only revolutionary strategies and activism would work to confront the on-going power struggles and hegemonic status of clinical authority in particular. A participant from Christchurch protested that, “When you are trying to wrestle power from one group of people to another, sometimes building [positive] relationships is just about maintaining the status quo” (Team Leader 2, Focus Group A, Christchurch). Instead, he believed,

The big conflict is that the medical model remains dominant, and it needs to be challenged; the weaknesses need to be exposed; the abuse of human rights needs to be exposed; people need to be challenged at all levels about whether they are actually contributing to recovery or contributing to illness. (Team Leader 2, Focus Group A, Christchurch)

Advocacy, whether by organisations or individuals, was used in attempts to disrupt and ameliorate imbalances in power. Sometimes this involved directly challenging the status quo, encouraging service users to become critical of institutional hierarchies that positioned them at the bottom. Many reported, for example, a routine lack of professional courtesy with clinical staff regularly arriving substantially late for appointments, without excuse or explanation.

Advocacy battles around medication highlighted differences in perspectives about symptom control versus an “ordinary” life in community. This Waikato team leader described their “fights” with clinical staff who were only concerned with the “therapeutic dose” of medication, where the support work staff were arguing that “this person can’t function, they can’t have a life; all they are doing is sleeping all day” (Team Leader 3, Focus Group W, Waikato).

Peer support workers, in particular, discussed how important it was for service users to have support before and during meetings with clinical staff that were commonly experienced as manipulative and intimidating. More than one participant stated that relationships with professionals improved when a third party was present, just to witness the exchange. This senior manager from Christchurch observed, “The doctors definitely, and nurses, everyone behaves better when there is a witness, and it can be as simple as that” (Senior Manager 1, Christchurch).

However, individual, idiosyncratic strategies for fighting back were usually unsuccessful and mostly contingent on other favourable circumstances; set against a background of institutional power of which service users, at least, were acutely aware. One peer support worker explained that her own experience had only worked out because, “I had my best friend who is a clinical psychologist who went in with her psychologist’s hat on, so I was taken care of. But it is still going on to this day and there are people not being taken care of” (Peer Support Worker 2, Focus Group PS, Auckland). Another described how necessary it was to support service user in these encounters, “because there is this very subtle blackmailing thing going on which I find very underhand, and I find it very unethical” (Peer Support Worker 1, Focus Group PS, Auckland).

Participants also spoke about mediating on behalf of service users at the boundaries and transitions between inpatient services, the community and the NGOs. One focus group discussed “trying to advocate for the person who’s [an] in-patient to get some things sorted so that he can have a reasonably smooth transition [into community services]” (Team Leader 1, Focus Group P, Hamilton). But sometimes resistance seemed to make things worse and a team leader from Hamilton described what happened when they tried to negotiate with the clinical team about a service user who specifically wanted a Kaupapa Māori service. She said, “He sat in respite I think for about four months before they finally said ‘Okay then, we will find him a kaupapa Māori service’, and he is doing really well now” (Team Leader 1, Focus Group A, Hamilton).

There was certainly a sense from participants that at some point they had to push back if only not to end up as scapegoats for problems beyond their control. It was clear that in these matters biomedical and managerialist professionals were powerful allies within the DHBs. A senior manager from Wellington described a DHB “culture of pushing it down and down . . . and at some point you have to go ‘No’ and push it back up. No. This is not my problem. I cannot safely do more than this and therefore I am not going to do it” (Senior Manager 4, Wellington).

At the more extreme end, participants were uncomfortably aware of the possible risks and consequences. A group of senior managers discussed their dilemma at being ordered to move a person to an inappropriate situation. One said, “If we had allowed it, that person would have crashed and burned and taken everyone [down] spectacularly. And that would have been his last bridge burned and he would end up in a really restrictive environment” (Senior Manager 5, Wellington). But another commented on their luck that they “didn’t get [clinical staff] down my throat” because “no doctor had bothered to turn up to that meeting” (Senior Manager 4, Wellington).

It was apparent, therefore, that efforts to challenge the institutional status quo by the community NGOs and service users, were largely ineffective. In the next section, I examine the efficacy of these efforts in terms of each of the institutional pillars (Maguire & Hardy, 2009), and their interactions, as these were evident in Aotearoa\New Zealand mental health services and the effects on NGOS specifically.

Undermining the institutional pillars

Participants displayed differing levels of awareness about the complex, institutionalised bases of social norms, biomedical authority and managerialism. However, they did explicitly criticise the local circumstances in which their organisations were situated, and challenged at least some of the institutionalised rationalisations underpinning the policies and directions of mental health services. Many challenged the socially normative attitudes of external society,

highlighting social and community accountabilities for creating disabling environments that reinforced institutional influences within their organisations. They echoed the Mental Health Commission (2012a) and noted that the community was frequently as much a source of problems as it was of solutions and many were critical of communities where “people are intolerant of any symptoms” (Senior Manager 1, Christchurch). Publicly funded campaigns, such as *Like Minds, Like Mine* (Vaughn & Hansen, 2004), have attempted to directly confront popular depictions, and myths of violence, associated with so-called mental illness. These appear to have been quite effective in shifting perceptions, and one participant opined, “People are more aware now of mental health services existing in communities. [Ten] years ago, mental health services [only] existed in hospitals. That is a huge, almost seismic shift for communities” (Senior Manager 2, Auckland).

However, while the promotion of recovery had clearly shifted some social assumptions about people with experiences of psychological distress, it was apparent that these had often been replaced with new social norms and expectations. In particular, participants reported unrealistic pressures for people to move rapidly through the mental health system and one peer support worker, for example, commented that new societal pressures amounted to “Well come on, you are going to be recovered; you have to get out there and do this or do that” (Peer Support Worker 3, Focus Group S, Christchurch).

Most participants believed that the future of mental health services was not with biomedicine. A team leader from Christchurch explicitly identified a “need to move away from a sort of scientific kind of perspective imposed on us by scientists in the form of psychiatrists and what not, to a more humanist kind of approach” (Team Leader 3, Focus Group A, Christchurch). The Mental Health Commission (2007b), also, explicitly looked forward to a near future where “there will be a different set of ideas about what mental illness is and what mental health is” (p. 14). This report goes on to contend that medication, also, will be “recognised as causing significant harm as well as providing significant relief in some cases. Some medications commonly in use today may be

unavailable by 2015 as the health risks they pose become better recognised” (p. 14). However, these examples seemed more indicative of desired, rather than observable, institutional change.

Medication remained the most vexatious and symbolic issue for participants. Participants with lived experience of serious psychological distress were not confident that mental health services offered much that was useful, and displayed an over-reliance on medication while personal preferences were routinely dismissed by clinical professionals. As one peer support worker explained, “I couldn’t get any help from the mental health [services and] when you do it is medication, medication, medication” (Peer Support Worker 3, Focus Group S, Christchurch). Another participant was even more radical in her frustration at the presumptive role of medication, advocating for a campaign of “complaint” in disrupting biomedical power and wherever possible “throw the research back at them” (Team Leader 2, Focus Group A, Christchurch). Individual instances of professional attitude change to prescribing were noted but these were clearly still the exception not the norm. A team leader from Hamilton commented that, “There’s not many psychiatrists that [will] allow people to not take their medication and continue on seeing them” (Team Leader 3, Focus Group A, Hamilton).

Participants also spoke of frustrations with the regulatory frameworks that supported managerialism and biomedicine within Aotearoa\New Zealand. These comments resonated with global movements to implement legislative changes that would increase the rights of mental health service users. However, despite national strategic plans, such as *Te Kokiri* (Ministry of Health, 2006) and *Te Tahuhu* (Ministry of Health, 2007) that have advocated for a stronger voice for service users in mental health service development, systemic sector reform has not been a priority in recent decades. Unfortunately, and historically, the political and societal drivers of the mental health policy agenda have been scandal and crisis. As this senior manager commented:

It doesn’t sit comfortably with me that mental health should be so crisis driven and politicalised, because usually the end

result of those crises are very messy indeed usually for families and for service users, and for the sector itself, and quite traumatising. I think mental health . . . should be a priority in every government's policy agenda, simply because mental and psychological well-being is all of our business.

(Senior Manager 2, Auckland)

Some participants looked forward to “the day that the whole area starts integrating and getting away from the biomedical model” (Team Leader 2, Focus Group A, Auckland). But overall, participant talk suggested that optimism about changes in Aotearoa\New Zealand mental health services was more indicative of the elaborative change typical of insider attempts at improvement rather than transformative systemic change. In the next section, I examine the ways that system and organisational change was evident in the sector and discuss the circumstances that supported or constrained these endeavours.

The times they are a changin': Trying to do it differently

Community non-government organisations, as “outsiders”, were clearly at the forefront of the struggle to replace socially normative and naturalised discourses and practices with innovative service models that more closely aligned with the recovery aspirations of service users. Indeed, the choice of methodology for this project was predicated on expectations of sharing “good news” and participants were eager to talk about change and tell stories of great outcomes for service users and their organisations. Despite the on-going difficulties these organisations faced, most were managing “doing more with less” resourcing (Senior Manager 2, Christchurch) and working within contracting constraints in order to drive and implement innovations that were considered best practice internationally (Peters, 2010). However, participants described organisational change efforts that displayed characteristics of either institutional insiders or outsiders, and these were correspondingly effective or ineffective in sustaining long-term change and organisational transformation.

“We just do it differently”: Innovation and the good news stories

As discussed in the Background chapter, the era of the Health Funding Authority in the 1990s was a potentially fertile historical moment for many “flax root” and innovative initiatives to be developed in the community sector. A senior manager from Auckland reminisced that as a funder at that time, he had been eager “to invest in the NGO sector as a way to extend and deepen the range of experiences that people would have of mental health services” (Senior Manager 2, Auckland). He added that the intention had also been to “expand mental health into the community in the way that philosophically it should have headed” (Senior Manager 2, Auckland). For all participants realising their best organisational intentions meant increasing expectations of, and creating opportunities for, organisational innovation and transformation.

There were significant differences among organisations, however, about the clarity of their articulation of their organisational vision, values and best practices. Organisations with strong philosophical foundations and values, consistently articulated throughout focus groups and interviews, correlated with endeavours to be more accountable to their constitutional values than to DHB contracts. Participants, who believed their organisations were effective in terms of recovery, all reported various organisational mechanisms for incorporating recovery, and synergetic approaches (such as strengths-based practices), throughout organisational discourses and communications. For example, a team leader from Christchurch talked about “strong social justice values that have been developed and massaged for 100 years at [our national organisation]” (Team Leader 2, Focus Group A, Christchurch).

Similarly, the presence of designated peer support teams and \or service user leadership within an organisation signalled organisational coherence and strength around values. Other forms of service user involvement also appeared to define best practice by removing institutionalised barriers between staff and service user. For instance, one Christchurch organisation had taken “the opportunity to put service users in front of other delivery staff in the wider organisation” which had the effect of reducing “the barriers between ‘us and

them', and there is much more tolerance and inclusion" (Senior Manager 2, Christchurch)

In some organisations, consumer advisory systems had evolved, from service users sitting outside service delivery teams, into fully participatory teams where service user voices were incorporated into all stages of organisational planning and practices. Similarly, a senior manager from Hamilton discussed their organisational processes aiming to ensure all voices were heard, as having "feed-in mechanisms, not feed-back; feed in: The way the people actually want things to happen in their service" (Senior Manager 4, Hamilton). This meant that all organisational stakeholders, especially service users, were informing the development of services and not merely commenting on the results. Other initiatives around the country included peer support services, peer respite services, packages of care, home-based support, community engagement, housing and employment support as well as endeavours such as Mad Pride concerts, theatrical productions and comedy galas (*Platform Trust*, 2008).

Many organisations used websites and newsletters to publish good news stories and successful outcomes to ensure the discourse remained alive within the organisation and provided a reference for organisational reflection²². Communicating a generalised optimism and belief in a person's capacity for creating a great life for themselves in their community also seemed crucial for sustaining organisational environments that provided effective support. This senior manager explained that her organisation maintained its connection to the values and recovery philosophy because "we have a really strong belief in people and in people's capacity to create a future for themselves" (Senior Manager 2, Christchurch).

Some participant organisations had contracts for peer support work teams and these were obviously very successful where they were available. The contracts under which "peers" worked with service users were significantly different from those for generic community support workers and generally

²² See for example, <http://connectsr.org.nz/>, www.framework.org.nz, www.wellink.org.nz/, www.centre401.co.nz, www.comcare.org.nz

encouraged a greater degree of autonomy for both worker and service user. These relational approaches validated the peer relationship and engaged with the whole circumstances of a person's life and community. They were perceived as the most effective in enhancing recovery. A senior manager from Hamilton described a major difference in peer support as not being "fear based". Instead, relationships were founded on trust and an assumption that people want to get better "because nobody wants to stay in that state" (Senior Manager 4, Hamilton). However, it was not evident why the flexibility inherent in peer support was not an aspect of other community support work contracts; nor why there were no outcome "measures" that evaluated the efficacy of such relationships.

Best practices also seemed to be a function of an organisation's capacity to encourage personal, professional and organisation reflection. Some organisations provided forums for organisational reflection and/or peer supervision and one had incorporated a "listening hour" where the CEO made herself available once a week just to listen to any member of staff on any issue, idea or topic they chose. Another explained that her organisation had "lots of peer mentoring and reflective practice happening [and] we challenge each other to do things better" (Team Leader 5, Focus Group B, Christchurch). Where it was working, organisational best practice invariably displayed coherence among communicative transparencies, strategic vision, and active engagement with community networks. Participants also invariably emphasised the value of service user involvement and peer run services in effective service development and some diverse and interesting developments were apparent, although sadly these tended to be localised rather than systemic.

Many participants commended the benefits of a strengths-based approach, noting that "having that positive focus consistently, trying to look for creative solutions" (Senior Manager 2, Christchurch) did not mean ignoring a person's struggles but focused on positive ways of managing them and drawing on a person's strengths to overcome barriers. However, surprisingly, few organisations identified as having an explicitly strengths-based philosophy and

the “strengths” discourse appeared to have dissipated from the landscape despite appearing in national texts and strategy documents. One Auckland organisation, however, remained committed to this perspective and the CEO described how this was sustained throughout organisational discourse and practice:

We are recognised as a strengths-based organisation, so all of our staff are specifically trained in the strengths model and the strengths approach. Our language, our culture as an organisation, in terms of our rituals and our infrastructure, our policies, our organisation infrastructure are laced with that notion of recovery as a central tenet and strengths as a key to working with people.

(Senior Manager 2, Auckland)

It was apparent that effective innovation still depended on being supported by key personnel at the DHBs. For example, a group of peer support workers spoke about an exemplary in-patient service that was embedding service user involvement by establishing regular consumer meetings and more client-directed initiatives. However, they added, the service was only developed at this site because of the head psychiatrist’s approval, and had not spread to other services within the DHB. Participants also spoke about the importance of real, informed choices for service users. As one service manager worker explained, genuine choice is more than, “would you like to be in the acute unit or would you like to be in this residential rehab unit?” (Senior Manager 1, Auckland). When provided with such an environment and opportunities to make important decisions for themselves, participants observed that service users quickly gained confidence and self-assertion.

Invariably, participants made distinctions between the NGOs and clinical services based on the provider’s capacity and willingness to be innovative and responsive to the holistic needs of service users. They frequently contrasted NGO initiative with a lack of common sense awareness that seemed characteristic of a tunnel-vision biomedical approach. Support Workers from

Wellington discussed how their organisation systematically managed a range of physical health issues for a person new to their service, including a serious hearing problem that had been interpreted by clinical teams as “He grunts when he talks”. One participant found it “amazing that it took one service out of probably 10 that he has been in to identify those things. He has been in those services for so long and nobody knew he had a hearing problem. To me that is disgusting” (Support Worker 7, Focus Group A, Wellington).

Most agreed that establishing good collaborative relationships with funders and regional clinical services was essential to effective outcomes for service users and the credibility of their own organisations. However, effective relationships appeared to be largely a feature of regional, historical and contextual contingencies

Collaboration, cooperation and common sense: Building effective relationships

An organisation’s relationships with its DHB funders and clinical teams had significant effects on its capacity to organise itself as recovery oriented. Effective, collaborative relationships were also clearly dependent on the history of service development in a region. Auckland, for example, straddling five DHBs, offered opportunities for engagement, coordination and collaboration among the community organisations that created some organisational power for advocacy and strategies for levelling the playing field over time. Despite the weakening of regional roles and a less favourable funding environment in the DHB era, providers there were able to maintain regional networks and sustain robust stakeholder involvement in the development of services. An Auckland senior manager described her experience of the importance of regional coordination, and the current manager specifically, in advocating for a unique niche in the sector. She stated, “He believes in recovery and he sees that NGOs are very effective at delivering some of the innovation around that and they are free to do things, less tied up with the bureaucratic requirements”. Importantly, she commented that this enabled the NGO sector in Auckland to “do things

differently. We don't have to be politically neutral. And [we] have a very, very different driver than clinical [services]" (Senior Manager 4, Auckland)

Senior managers were the participants who were most engaged in collaborative arrangements with DHB funders and clinical teams. Most of this cohort were confident about their relationships with DHB personnel, but conceded that they required considerable energy - an effort that was not usually reciprocated. As one Senior Manager commented, "We need to put too many resources as an organisation into having a good relationship with the funder, which you know that is not ideal" (Senior Manager 4, Auckland). In some cases collaboration appeared to be a contractual requirement for the NGOs but not clinical services. A senior manager from Christchurch remarked it was "the community organisations that [make the effort] because we are the ones who have to demonstrate for our service specifications that we are linking in with [them]" (Senior Manager 2, Christchurch).

Unfortunately effective relationships also remained heavily dependent on the personnel and personalities involved, particularly the attitudes and receptivity of clinical or DHB portfolio holders. An Auckland senior manager commented that organisations could only "fight these battles as long as people on both sides actually have to turn up and fight them" (Senior Manager 3, Auckland). Another observed that they "didn't have a great relationship with our last funder" but that "the new one is really on the same wave length as us [and] she understands what we are doing, which is really useful for us". However, she admitted that it was "not ideal that driving our collaboration [is] the fact that we get on with her" (Senior Manager 1, Auckland).

Other participants were wary of collaborative arrangements that had the appearance of partnerships but reinforced hierarchical relationships between NGOs and clinical services. A team leader from a service user organisation in Hamilton described how a representative from the DHB wanted their cooperation in the development of a new Integrated Recovery service; specifically to identify how it might work. She described how together they "made up a big plan: How we could do that and what would be really cool [and]

how we could work together. [And then] he went away and we never saw him again. [Our work] wasn't included in it" (Team Leader 4, Focus Group A, Hamilton).

Some participants noted that positive relationships with professionals were characterised by a willingness to forgo institutionalised thinking and work collaboratively with mutually respectful communication and equitable engagement. This was happening in places and a team leader in Waikato had noticed positive changes where "good doctors who will actually look at things and [see] that things are not working and actually work through that, and try changing things and doing other things" (Team Leader 3, Focus Group W, Waikato).

A few organisations were engaged in collaborative ventures that employed psychologists and other clinical staff. A team leader from Auckland spoke about initial scepticism of a collaborative service established as a "one stop shop" in South Auckland. She explained initial anxieties were that they would be "swamped by a clinical model". However, she added, in the end, there had been a good deal of learning in both directions and that "clinicians have moved on themselves hugely" (Team Leader 5, Focus Group A, Auckland). Similarly, in Hamilton, a team leader described how it took a new clinical coordinator to recognise the need for a totally fresh strategy to resolve a situation that had become stagnant and confrontational over several years. Changes had meant that the service user was now "the happiest I've ever seen him. He goes to see a psychiatrist once every three months, but there's no medication involved. They've got this deal worked out." (Team Leader 3, Focus Group A, Hamilton)

Other participants noted the good intentions of some DHB staff, but that underlying conflicts in paradigms and values compromised effective collaboration. A senior manager from a service user organisation in Christchurch claimed that good will alone was insufficient where conflicting translations of recovery were present. She said, "I see a great keenness and willingness to be helpful, I see an urge to be efficient . . . efficient and fast [and] I don't think that

works with a recovery model because [for example] there is a tendency to use drugs more quickly than there is to use de-escalation; there is just this straight line from the money to the behaviour and they don't [take] time" (Senior Manager 1, Christchurch).

It was apparent that, in some service environments, inter-organisational relationships were improving. A senior manager from Auckland noted that clinical staff had reported favourably on their collaborations with support workers saying, "When it works it is fabulous, it cuts down on my workload, it cuts down on the number of meetings and assessments and paperwork [and] I think we can assume that that is a positive outcome for the client. [And] there is a sense that things are more generally person centred" (Senior Manager 1, Auckland). Other participants noted that in some places "clinical teams have now started to include the support worker" (Support Worker 3, Focus Group A, Wellington) and that they were "starting to pay attention to what [the] service user is saying" (Support Worker 1, Focus Group A, Wellington). Another support worker commented that she had observed a psychiatrist who gave a client information about a range of medications and let him/her choose his/her own, preferred, option. However, she noted, this was "a first" (Support Worker 7, Focus Group A, Wellington).

Unfortunately, effective relationships appeared to remain largely personality driven and therefore idiosyncratic. One senior manager said, "If we have a good support worker and a good clinical key worker, [it] is fantastic, very collaborative, very mutually supportive. If you have a bad support worker and a bad clinician then god help you" (Senior Manager 4, Auckland). Participants also noted, somewhat surprisingly, that psychiatrists appeared more receptive to challenging traditional professional boundaries than clinical staff lower in the hierarchy. A group of peer support workers noted that recent changes in an in-patient unit were positive because "the head psychiatrist there is all for it" but that was "less so in the clinical and community teams" (Peer Support Worker 6, Focus Group PS, Auckland).

Participants also commented that when clinical staff were willing to work with an expanded sense of a person's capabilities, strengths and recovery aspirations many were pleasantly surprised at the outcomes and relished the creative opportunities they offered. A team leader from Auckland described some clinicians as saying " 'This is so much fun.' And [the clinician] has really given it their best" (Team Leader 5, Focus Group A, Auckland).

Most participants positioned themselves, and their organisations, as *outsiders* to strategic change in the sector, but some senior managers, who had worked previously in DHB clinical or funding roles, displayed perspectives that were more accepting of the status quo, and were thus more typical of institutional *insiders*. Their talk was noticeably ambivalent with respect to the institutions, characterised by phrases such as "just getting on with it" (Senior Manager 2, Auckland), and emphasised service improvement rather than radical change and organisational transformation. In the next section I compare these endeavours as exemplary of insider or outsider efforts, and examine their utility in terms of organisational and system change.

Struggling to disrupt: Insider versus outsider efforts at sector change

Maguire and Hardy (2009), noted that institutional insiders tend to defend existing practices and participants from insider backgrounds generally seemed overly sanguine about how far the system has come towards a recovery orientation. They also adopted a standpoint of *improving* rather than *transforming* services. One senior manager, from a clinical and funder background, seemed unequivocal in endorsing organisational improvement rather than system transformation:

If we keep striving to improve, then one would hope by default our service delivery will get better. Are we seeing enough people? Do we have the right blend of staff? . . . Is the skill mix right? . . . So I think that there are organisational improvements that we can always make that will make our

service delivery better or even enhance it.

(Senior Manager 2, Auckland)

In contrast, system *outsiders*, who included most participants and especially the peer support workers, are invested in transformational change because the status quo typically disadvantages and disempowers them. People with lived experience of psychological distress, for example, have had the most to gain by destabilising institutionalised discourses that have accounted for their experiences in terms of biomedical pathology. As outsiders, however, they have limited avenues with which to challenge and disrupt institutional powerbases and always appeared to be struggling to control the meanings and discourses of recovery. This generally meant that efforts to do so were largely localised and mostly ineffectual.

Participant insiders also appeared tolerant of expediency for the sake of organisational sustainability. An Auckland senior manager admitted that “there might be all sorts of expediency and politics, [but] that is just what makes the world go around” (Senior Manager 2, Auckland). Those with DHB backgrounds believed this gave them greater insider understanding and a capacity to negotiate whereas, in fact, considerable compromise was evident. Some of those from insider DHB backgrounds also acted as “translators”, even attempting to reconcile oppositional discourses by positioning bad practices as isolated instances rather than systemic. For example

I don't think the conflict is about the medical model and the recovery model and the rehab model. I think it is about people and their ability to work well together and listen. Good clinical Western medical model is about listening, and it has been given a very bad name in my view because of very bad practitioners. (Senior Manager 4, Auckland)

Similarly, insider participants accepted their primary accountability was to deliver on their contracts with government funders rather than recovery outcomes and service users. This worked against any systemic will to increase flexibility in organisational practices and service delivery models. One senior

manager explained that being contracted meant his organisation “had an obligation to meet the demands that those place on us in the first instance” (Senior Manager 2, Auckland).

However, there were also strategic implications for maintaining goodwill with DHB funders and several senior managers discussed the need to “make it work”. Some admitted that they self-consciously negotiated for small concessions to create some flexibility in contracts. This was much easier for larger organisations or collaborative alliances to effect. An Auckland senior manager remarked,

Intentionality is about what battles I am going to pick; how I am going to turn this relationship into a positive affirming relationship; how I am going to build the ‘bank balance’ up, so when I need to draw on it I can. That’s intentional, absolutely intentional. (Senior Manager 4, Auckland).

Another manager, trained as an insider but who of her own volition had become a maverick, railed at the inability of insiders to effect transformational change. As she said:

The minute I [graduated from Occupational Therapy] I saw a system that doesn’t even begin to think it is going to help people. It is shocking. And meanwhile I watch all the professional bodies getting more and [more] esteem. Well use that [to provide] some leadership, and actually advocate for the things that you see around you all the time. Doctors and nurses could have so much influence in our system to change things, why are we leaving it to service users.

(Senior Manager 4, Hamilton)

Other maverick insiders also advocated for system transformation from the inside out, although they remained aware of the potential risks involved in following an unauthorised path. One senior manager from Wellington argued that organisations needed to be “sort of on that boundary edge, that is the area

where your best work is [done]. It is stepping in a place where if something does go wrong you could really get slammed with it” (Senior Manager 2, Wellington).

Although insider change might be difficult, with privileged groups being unable or unwilling to redistribute power and resources, outsider change efforts were also frustrated due mainly to their lack of credibility, voice and legitimacy. These participants felt discouraged that many opportunities for involvement in change were ineffectual because the space was dominated by institutional professionals. A senior manager from Hamilton remarked that forums and networks were “actually there for the professionals and for the people who want to decide where the money goes. The people who are interested in how people get well aren’t usually at those forums” (Senior Manager 4, Hamilton).

Others, however, believed there was strength in numbers and that provider networks and sector collaboration provided a collective voice and were therefore more powerful in effecting sustainable system change. In Auckland at least, provider forums were perceived as effective because “there is mutual gain to be had” (Senior Manager 3, Auckland). This senior manager added that the providers all had “really good experiences under our belt and we will work closely together and achieve results which neither of us could have achieved by ourselves”.

Outsider participants regularly engaged in insubordination and chose opting out, or “non-compliance”, as a form of resistance. Some insisted on working in accordance with their own values and sense of best practice despite the risk of censure. A service manager from Auckland commented, “We are actually doing what we know people want and what works” (Senior Manager 1, Auckland). Other attempts at disruption actively challenged institutional processes, some more effectively than others. A team leader from a family support service in Hamilton had developed his own strategy to interrupt the revolving door cycle. He developed a ‘Do not Discharge Home’ letter that went into a person’s file. This meant that clinicians were blocked from discharging people to a stressed family environment. He commented:

Of course, when the clinicians see those it gets in their way; it gets in their face. But at the end of the day the person who's got the illness is no longer at home where things weren't good. [It] gives the environment a chance to recover. (Team Leader 3, Focus Group A, Hamilton)

Essentially participants were utilising such strategies to manage the conflicts inherent among different translations of what recovery-oriented services should look like. Some endeavoured to instigate organisational change by being “non-compliant” and doing what they believed should be done, despite contracting and funding limitations. These efforts were necessarily localised and often furtive. An Auckland participant explained, “If the need is there [a] lot of people do it surreptitiously”. However, he added, “if a clinician comes along?” and left the sentence hanging (Team Leader 4, Focus Group A, Auckland). Another commented, “I am only supposed to do two projects a year, and I am doing four a week. And [the funders] keep saying to me, ‘You don't need to do that.’ And I say, ‘I *do* need to do that.’” (Senior Manager 2, Hamilton).

One strategy was to opt out of the system, and its insider processes and forums, altogether and focus efforts on transformative change. This senior manager protested, “We could spend the next 20 years commenting on a system that we haven't seen change in the last 10” (Senior Manager 4, Hamilton). She explained that her organisation's current relationship with the local DHB meant,

We are not even interested. I do not want to comment on their system. If it steps on our toes I will say something, but I am not going out of my building to get involved, I am not interested anymore in what they are doing. All of our energy will go into creating something different.

(Senior Manager 4, Hamilton)

While such activities helped participants feel more assertive, they had little or no effect on system change. Many participants expressed frustration that even common sense actions, fundamental when working with someone to

reconnect them to their lives and communities, were ignored or devalued by DHB goal planners. A senior manager from Christchurch compared this to “sticking things around a person, like a finger in the dyke” (Senior Manager 2, Christchurch). She went on to say, “If someone is struggling with managing their household stuff, [they] give them a housekeeper and a gardener or something like that. And then that just gets tacked on. Nobody suggests why don’t you have a community support worker? Who sits side by side with the person and teaches them how to do that stuff. And the [service users] become disempowered” (Senior Manager 2, Christchurch).

Instead a great deal of participants’ energy was being expended in struggling to meet the needs of service users as well as the requirements of their contracts. This was particularly frustrating as they all had great stories of successful outcomes for service users and best practices for a recovery orientation in their organisations, but these innovative ways of working were still not becoming the sector norm. In the next section I examine how participants discussed possible and future strategies change in their organisations and the wider mental health sector.

Future trends and the way things “should” be

Some participants discussed strategies for developing a greater degree of organisational autonomy. It was apparent they had carefully thought through these initiatives, “with the power of consumer voice behind them, and staff voice you know; we don’t just pluck them out of the air”, one senior manager explained (Senior Manager 4 Auckland). Several organisations were actively seeking alternative sources of funding to reduce their dependency on DHBs and establish a sustainable entity that “wouldn’t collapse if it lost all of its contracts” (Senior Manager 2, Christchurch). Another senior manager noticed that a trend towards more collaborative practice was becoming informed by “what is best for consumers, what the research is saying, about integrated treatment being better for outcomes”. She was hopeful that the trend would continue and not be influenced by resourcing issues i.e. “an expectation that we do more for less money” (Senior Manager 1, Auckland). Others believed political activism was a

necessary stratagem to create social awareness and influence environmental change.

However, most noted that the factors most likely to impeded positive change were resourcing problems; with DHBs increasingly needing to rely on community NGOs as partners because they are cheaper but also because there are worldwide shortages in clinical staff. Several viewed this circumstance as an opportunity to improve service user experience throughout the system. For example, in Auckland at least, there were moves to provide respite care in a person's home and one senior manager believed that there were indications that this would continue. As he commented: "We are lucky here that Aotearoa\New Zealand has a very strong consumer movement which is a lot more effective in driving change in the [community] sector because they don't have their hands in their wallets" (Senior Manager 3, Auckland).

Many participants echoed the sentiment that the DHB clinical and funding arms needed to educate themselves about what the NGOs were and could be doing; especially what was already working in terms of people's recovery journeys through the mental health system. A support worker from Christchurch thought that someone with authority needed to spend time with different organisations and "watch what goes on and just learn. And then at the end they are going to be able to say, 'these organisations are doing really well, these other ones may be not good for the future.'" (Support Worker 3, Focus Group S, Christchurch).

Others stressed the importance of the support worker role and this was reinforced by the perspectives of participants who also had personal experience of serious psychological distress. Some noted that previously people "were taken out of hospital and dumped in the community again and that was it" (Peer Support Worker 3, Focus Group PS, Auckland) whereas now community support workers were available. While this was seen as a positive for service users, there was scepticism about "whether it has any clout at the moment in changing the mental health [sector]" (Peer Support Worker 1, Focus Group PS, Auckland).

Others were cautiously optimistic that more collaborative projects and relationships were happening with a senior manager noting that people in the sector were now talking about collaboration and “recognition of the need for that”. But, again, she reflected, “there is not always a smooth transition” and that was “based around personality and history” (Senior Manager 1, Auckland). On the other hand, significant national strategy and policy texts increasingly referred to the “changing nature of the workforce” and trends in “workforce mix”, but this applied only to clinical or other health professionals such as social workers and occupational therapists. This further reinforced the impression that NGOs were being systematically devalued and discounted as important contributors to a recovery-oriented mental health sector.

In the end, most participants displayed little confidence that their efforts, from within the NGOs, were effective in disrupting and destabilising institutional forces. Many echoed Mary O’Hagan (2009) in referring to the colonisation of recovery and several compared the optimism of the *Blueprint* (Mental Health Commission, 1998) era in the mid-1990s with what they saw as worrying trends happening currently. One senior manager from Wellington expressed his dismay that, having thought a more enlightened era was on the horizon, in fact it was “a big dark hole now”. He said, “You wouldn’t think you would lose ground so much” (Senior Manager 5, Wellington).

In the next section, I explore the ways in which the institutions could be seen to defend themselves from threats to their power and legitimacy.

The empire strikes back: Counter challenges and defensive institutional work

In addition to the various discursive strategies discussed previously, the institutions could be seen to actively employ a range of strategies to systematically defend against organisational and sector change in Aotearoa\New Zealand mental health services. They effectively defended challenges to their power, legitimacy and authority, while resisting emergent discourses of recovery (Maguire & Hardy, 2009; Reay & Hinings, 2005). The findings of this research

highlighted strategies of defensive institutional work that included overt hostility to the NGOs as well as systematic efforts to ignore and devalue their roles. They also indicated significant institutional backlash at recovery itself. Relationship asymmetries between NGOs and DHBs were frequently exploited resulting in contracting and service specifications that increased clinical oversight and risk management practices that effectively curbed the autonomy of the community organisations.

Many of these defensive strategies were evident at national, and even international, levels; including a global move towards evidence-based practice that reasserted biomedical epistemological dominance and illustrated discursive closure around the nature of valid “evidence”. But increasingly evident, since the establishment of the DHBs, were strategies that systematically eroded the voices and independence of the community NGOs as credible participants in the Aotearoa\New Zealand mental health sector.

In this section, therefore, I look first at examples of how the institutions, especially those sanctioning biomedicine, positioned themselves as “embattled”, or under threat. In addition, I examine how biomedical professionals responded to crises or incidents by blaming community expectations, individuals and the NGOs. I then consider evidence of a clinical backlash against mental health services for being “too far down the recovery road”, followed by examples of actively hostile acts towards some NGOs perceived as troublemakers. A further discussion highlights how participants believed they were increasingly being devalued or ignored by DHB personnel as institutional agents. There was also evidence of the erosion of the “new” subject positions as well as lip service, or tokenism, towards recovery and system change. Fourth, I examine the strategies used to pull community organisations firmly under the clinical umbrella in order to keep them compliant and subordinate. Finally, I examine how many participants believed that their organisations were being systematically funded to fail.

Under threat: Positioning the institutions as embattled

The institutions, and especially biomedicine, increasingly positioned themselves as embattled, or under threat, in sector texts (Ministry of Health, 2001a). These included disingenuous, and contradictory, assertions that shifted responsibility for mental health service “failures” onto individuals or communities, and minimised or discounted organisational, political and social realities. For example, clinical professionals and others typically responded to reports of crises and service failures in the media as the inevitable result of clinical staff shortages or by blaming other sector stakeholders (Mason, 1996; Ministry of Health, 2001a, 2012; Pilgrim & Rogers, 2009). This deflected attention away from any institutional accountability; despite the basis of professional, legitimised authority being their mandated responsibility for the behaviour of individuals and the safety of communities.

At first sight, it appeared that the institutions sought to be excused their failings because their power was accepted reluctantly. Even the Mental Health Advocacy Coalition (2008) appeared to be tolerant of clinical services on the basis of their “politically charged role of containing and controlling some people”, while simultaneously acknowledging that these services tended to “lose their focus on the needs and views of people who use them” (p. 26). The coalition also implied that communities themselves were responsible for an undue burden on biomedical professionals, because they “have abdicated all responsibility for people with severe mental distress to mental health experts and services” adding that “if something goes wrong mental health services are habitually blamed” (MHAC, 2008, p. 26). Yet, one of many clinical submissions to the *non-clinical* services review insisted, “the specialist service *must* be in the lead role, assessing the clinical risk and providing continuity of care” (Ministry of Health, 2001a, p. 43). Additionally, given the privileged voice of medical practitioners in determining mental health policy and practice, the argument of responsibility reluctantly accepted seemed rather tautological.

Subtle, and not so subtle, references to *dangerousness* and *risk* reinforced the socially normative justification of the “responsibility of clinicians”

and the “expectations of the community” (Ministry of Health, 2001a). Unfortunately, clinical narratives of risk, fuelled by sensationalised media events, fed risk-averse practices such as the use of compulsory treatment, locked wards and security guards. Some participants also appeared to blame social attitudes for risk-averse environments without recognising or challenging this as a strategy that maintained bio-medical and managerial institutional power. However, others were conscious that some professionals wanted to have it both ways. A senior manager from Christchurch remarked that the clinicians’ stance on risk was about “covering one’s butt” and she was sceptical about the rationale that they “are the ones that end up in the coroner’s court”. She argued, “Actually everybody who works with the person will end up in a coroner’s court if what they have done is not to the best of their ability” (Senior Manager 2, Christchurch).

Risk aversion policies, practices and procedures functioned as mechanisms that constrained organisational practices and defended the institutions against innovation and change. A senior manager from Auckland maintained that the emphasis on risk management merely served to reinforce relationships of power and devalued the role of the NGOs. She explained that clinical services held the attitude that they “hold the risk things, so ‘you must be directed by us’ [and] that we will do the cups of tea and shops that kind of stuff” (Senior Manager 1, Auckland). Another remarked, with irony, that “It is obviously much safer if psychiatrist is king” (Senior Manager 3, Wellington).

The insistence on risk management also encouraged a renewed emphasis on negative reporting and incident recording. A senior manager from Auckland reported an auditor’s alarm that her organisation was, “ignoring our responsibility to at least report, in terms of what was going on, in a negative way” (Senior Manager 5, Auckland). Another participant noted that “There are so many fears around risk, because of different things, that you can lose sight of the fantastic things that [we are doing]” (Senior Manager 2, Wellington).

The sense that the institutions, embodied in the DHBs, considered themselves to be under threat and needed to reclaim the territory was also

indicative of a defensive institutional backlash against recovery itself. Managing the clinical community organisational boundary, therefore, meant withstanding the consequences of resistance or an institutional backlash. This form of defensive work was the major barrier to the development of a unique niche and identity for the community mental health sector.

Too far down the recovery road: The institutional backlash

Alternative discourses such as recovery have provoked significant critical backlashes from psychiatry and other clinical professions (Craddock et al., 2008; Davidson et al., 2006; Ministry of Health, 2001), although some professionals were equally vehement advocates for change (Bracken & Thomas, 2010; Barker & Buchanan-Barker, 2011). Several participants spoke about a clinical backlash that included punitive consequences for individuals and organisations perceived as being *too* recovery oriented. This echoed concerns in some clinical literature that recovery was merely an irresponsible fad (Davidson et al., 2006). A senior manager from Auckland, speaking about recent reviews of the Auckland hospital acute facility, the Connelly Unit²³, remarked that, “The clinical director lost his position because of the perception that they had travelled too far down the recovery track” (Senior Manager 3, Auckland).

These institutional counter-challenges to recovery were clearly motivated by a desire to defend institutional power rather than any consideration of beneficial outcomes for service users. As one senior manager from Wellington explained, “None of the rationale about this is that [we] are going to be more effective in terms of helping people regain their lives” (Senior Manager 2, Wellington); another added, or “how we will stop that injury that happens to people who go into the unit on top of their illness” (Senior Manager 5, Wellington).

In addition, and perhaps more insidiously, there was a sense that, for clinical and DHB services, recovery had merely been an aberration in the “natural” flow of ideas over time. This was echoed by some participants as a

²³ An acute, high and complex needs hospital facility in Auckland.

kind of insider resignation which reinforced the clinical backlash apparent in some of the literature (Craddock et al., 2008; Davidson et al., 2006). A senior manager in Auckland remarked that “recovery now has had its time, and it just seems to be the natural order of things”. He was also unconcerned that “different people in different parts of the sector use [recovery] in different ways, and that is fine” (Senior Manager 2, Auckland).

In contrast, the submissions of service users and others to the non-clinical services review (Ministry of Health, 2001) invariably referred to recovery principles and the importance of a holistic approach to mental health services. These submissions warned that “proposed [clinically-based needs assessment] models would result in lack of choice and responsiveness to local issues” and concluded that clinical models “create uniformity for the sake of it” (Ministry of Health, 2001a, p. 32). Yet clinical responses to the review were frequently defensive. One clinician, for example, was aghast at the proposal that needs assessors or support coordinators “without a health professional qualification [could] assess consumer needs” (Ministry of Health, 2001a, p. 22).

It was evident that the hierarchical boundary between clinical and community NGOs was strongly demarcated, and vigorously defended, by most clinical services and other institutional agents. In some cases their relationships with NGOs were overtly hostile and exacerbated by an apparent intention, in several regions, to further undermine the NGO sector.

Hostile environments: What we do with troublemakers

Participants were aware that positive circumstances could change without warning as the institutions defended themselves against encroachment on the territory. The senior manager group in Wellington spoke about a five year era where there had been “a constellation of favourable factors for recovery” (Senior Manager 4, Wellington) in their DHB region; collaboration had focused on recovery and DHB staff were purposeful about looking for alternative ways to deliver many of the services in the region. Everyone, including psychiatrists, was trained in intentional peer support. But when key personnel at the DHB were

replaced “a very exciting process [became] a very frustrating and then devastating process in the end” (Senior Manager 5, Wellington) and the “climate that was very, very favourable [became] very, very unfavourable, and discussions seem to have gone back 10 years” (Senior Manager 2, Wellington)

Several participants, from throughout the country, reported that DHB funders exploited their power to advance their own interests at the expense of the NGOs. In one instance, an independent review evaluated all youth services in the area and the results “really upset the applecart” as one participant put it (Senior Manager 1, Hamilton). And yet, “the contract was taken off the ones that the [review] said were cool [and] given to the two [DHB] ones that weren’t rated so well” (Team Leader 4, Focus Group A, Hamilton). Others questioned how they could “beat that system when you know you are doing a good job, that you have the results” and when “clients who are totally unhappy about what is happening, and it is completely out of your hands” (Support Worker 3, Focus Group S, Christchurch).

Others were disturbed about having to take a defensive approach to service delivery to cover contingencies, and in the worst cases some organisations saw themselves under threat from their DHB contractors. For example, a senior manager from Wellington explained that it was hard not to be constantly warning staff to “be careful please; count everything, please record everything” rather than “having a healthy, open, creative way to approach our service users [just] to cover ourselves, for no positive reason” (Senior Manager 4, Wellington).

However, participants were wary of the threats posed by challenging these circumstances or even advocating on their own behalf. One senior manager remarked that “we are in too vulnerable a position to be whistle blowing” (Senior Manager 2, Wellington), while team leader from Hamilton observed that “the power that the DHB has to be able to pull funding if you don’t play the game as an NGO” (Team Leader 3, Focus Group A, Hamilton).

Asymmetrical relationships with DHBs created many vulnerabilities for the community NGOs. In one instance, a group of Senior Managers discussed

being effectively immobilised by DHB funders simply rebuffing attempts to engage with them. One observed that the emails of their CEO “are not even being acknowledged” (Senior Manager 4, Wellington) with another describing being stonewalled as “a really horrible experience” (Senior Manager 3, Wellington). This sense of a potentially hostile environment was apparent at all levels of inter-organisational relationships and the costs of compliance seemed to require a disproportionate amount of effort and energy for the NGOs.

In addition, several participants, from all regions, spoke of personnel and role changes within the DHBs as being highly reactive. An organisation in Wellington, for example, who had established very effective relationships with previous DHB portfolio holders, experienced a change in personnel that was dramatic and hostile. One remembered that an “overcorrection came in a pretty devastating way” and that the organisation had been “served up a surprise audit which was pretty vicious and hostile” (Senior Manager 2, Wellington). This was contrasted with previously effective relationships among NGOs and DHB personnel:

The previous [DHB] regime several times got NGOs together, when there was [any] critical situation with the ward and [we] came up with solutions. This lot are having no dialogue as far as we know . . . with the previous regime there would have been a supportive learning approach to any incident, and with this one it will be used to hang the NGOs out to dry.

(Senior Manager 1, Wellington)

The theme of stifled innovation was recurrent and initiatives from NGOs appeared frequently to be ignored, unsupported or actively undermined. Many participants were worried about the trend for the community organisations to become more clinically focussed. A support worker from Wellington was concerned that “out there, in DHB land” this would “kill all this stuff, the creative [stuff], this being in the world [of the service user] and finding out what is going to work for them” (Support Worker 6, Focus Group PS, Wellington). A participant from Hamilton commented that “No matter how innovative NGOs

can be, or anything else, it's still driven by medical decisions by clinicians" (Team Leader 3, Focus Group A, Hamilton). She added that if clinicians are "very risk averse, [and] draconian" then "you can't do anything innovative if they are vetoing it" (Team Leader 2, Focus Group A, Hamilton). Similarly, an organisation involved in the proposed development of an innovative community service provoked a sharp counter attack based on "the usual things. That it wouldn't be safe was their most loud concern: it wasn't a locked environment; NGOs don't know how to employ clinical staff; the usual" (Senior Manager 5, Wellington).

In general, DHB efforts to declare their authority was exemplified by the increasing trend to dismiss and devalue the role of the NGOs. In fact, trends that promoted the development of the peer support workforce appeared to have done so at the expense of a niche for generic community support and the NGOs, and deflected attention away from their role in sector transformation.

If we ignore you, will you go away

Discursive closure was effectively employed as a defensive strategy when participants tried to engage DHB managers with alternative discourses of organisational transformation and institutional change. A senior manager from Wellington explained that, despite his organisation having international renown for leading innovation and best practice, "the new [funders] don't know anyone in the mental health sector, so our literature and [international] support means nothing to them because they don't understand how important it is; they don't know the people [or] which ones to listen to" (Senior Manager 5, Wellington).

Several participants commented that some DHBs sought to further reduce the legitimacy and power of the NGOs by actively eroding relationships on the basis that "there were too many providers anyway" (Team Leader 4, Focus Group A, Christchurch). This diminished any influence the NGOs might retain because the DHBs were "not worried about their relationship with us" (Senior Manager 3, Auckland).

Similarly, the same group discussed how the DHB used "silence in a very strategic way" (Senior Manager 2, Wellington). One explained that they were

often told that “issues would be resolved at the next meeting but “then you don’t hear about it again. He added that when the organisation’s Board wrote to their DHB portfolio manager to raise their concerns it had “never been answered” (Senior Manager 2, Wellington). Other participants reported that DHBs were often tokenistic in an appearance of progress while systematically devaluing the role of the NGOs. A team leader from Christchurch remarked, that despite regular meetings “things don’t always progress any further, I would like to say some of it is a complete waste of time” (Team Leader 2, Focus Group A, Christchurch).

These NGOs’ frustration was frequently accompanied by disappointment that initiatives which had the appearance of progress had turned out to be mere window dressing. For instance several participants commented on new reporting requirements that included a narrative component. These had been welcomed initially as opportunities to tell the good news stories of successful recovery. But people became disillusioned when it was apparent that these were not influencing service specifications. In many cases it was not clear that these narratives were even read, let alone having any efficacy in determining policy direction. For instance:

I stopped doing those stories when [the DHB] came to us once and said, “We would like you to give us a whole lot of good stories and bad stories.” I said “I have been sending you two a month for the last three years.” I am not writing anymore. You know it was ridiculous, where are they?

(Support Worker 8, Focus Group A, Wellington)

Overall, participants were sceptical that their voices were included in sector change efforts; nor did they think these reflected the community organisations’ values or discourses of recovery. They were unconvinced that the information being gathered from them, and about them, was leading to tangible, observable change in policy and service specifications, let alone whole system transformation. Many concluded that the “wrong” data was continuously being fed into planning and service development rather than accounts which actually

represented what was working well in their organisations. One senior manager described reporting requirements as “the most bizarre questions” (Senior Manager 2, Christchurch) in terms of what the organisation was actually doing. Others were frustrated by a general lack of feedback from DHB portfolio managers.

We had an audit, and there was no real feedback about some of the things that we had put in place, the innovative approaches, that sort of thing. They wanted to hear about it, they wanted us to evidence it, and so we did, but again there was no feedback in regard to those things that we were doing. (Team Leader 3, Focus Group A, Christchurch)

Others had attempted to compensate for statistical reporting by developing their own, more meaningful, processes to record what “really counted” (Senior Manager 2, Christchurch). Although such attempts meant “quite a bit of work for us” they reported that staff felt “quite energised about it. For the first time they are actually recording what they do, which is good [and] they are really happy about that” (Senior Manager 2, Christchurch)

It was also apparent that institutional defensive work included the systematic erosion of the new subject positions of the recovery era. A steady decrease over time was apparent in references to the important role of community organisations in national texts; alongside a corresponding increase in emphasis on assumptions of clinical superiority, efficacy and benevolence (Ministry of Health, 2005, 2006, 2012c). Similarly, reference to the harmful impacts of treatment services on people’s lives had all but vanished from national policy and strategy documents. The role of the Mental Health Commission (2012a, 2012b) was similarly eroded when the constitutional requirement for at least one commissioner to be a person with experience of serious psychological distress was removed. This was followed shortly afterwards by the dissolution of the Mental Health Commission itself in 2012.

DHB staff also used their power to stall new initiatives with tactics such as not referring to new services. Designated peer support workers reported that,

even when psychiatrists supported their work, they were frequently “being blocked, it is not being allowed” (Peer Support Worker 5, Focus Group PS, Auckland) by clinical staff further down the hierarchy. Similarly, a team leader in Auckland explained that a pilot project which “everybody said was a really good idea” was stonewalled because “referrals were very, very slow in coming through” (Team Leader 5, Focus Group A, Auckland). She believed that this was because DHB staff were “reluctant to relinquish some of their control [and] to try new things” (Team Leader 5, Focus Group A, Auckland). Similarly, new services were not being promoted and a peer support worker in Auckland commented that “It seems to be down to the management at those places as to how openly our service is accepted and how the information is passed onto people”(Peer Support Worker 2, Focus Group PS, Auckland).

These tactics were accompanied by an increasing insistence in contracting on “clinical oversight” of the NGOs, which could be seen as a defensive move by DHBs to increase control over these organisations and block alternative practice models.

Being pulled under the clinical umbrella

Most participants reported the NGOs being pulled under an ever enlarging clinical umbrella; thus formalising their positions of subordination. “All our contracts are linked to ensuring that our clients have a clinical manager” stated one senior manager (Senior Manager 3, Christchurch). Many were concerned that people wishing to be referred to services such as peer support were required by the DHB to have a clinical assessment, or in other words they needed to have the “label” before they could get support which many were reluctant to do. Others remarked that their organisations were having to become more clinically focused. For example, one support worker noted that: “We now have a clinical advisor which we never had before. [We]used to [pride ourselves on being] a non-clinical organisation” (Support Worker 1, Focus Group A, Wellington).

Some participants hoped that the establishment of collaborative one stop shops would increase the legitimacy and credibility of the non-government sector; but it was evident that many of these arrangements merely reasserted clinical dominance. A manager from Auckland admitted that it was “difficult to promote truly collaborative practice which isn’t just about ‘Let’s get together to talk about what you have done wrong’” (Senior Manager 1, Auckland).

Many of these new arrangements and requirements utilised the discourses of “risk” and “risk management” to further bolster clinical authority. A team leader in Wellington described being compelled to follow the strict guidelines of their contracting requirements, saying, “If we try to deviate from these instructions, then we are not cooperating with primary clinicians and ‘What kind of organisation are you that can’t follow these simple instructions?’” (Team Leader 1, Focus Group B, Wellington). Other participants were similarly anxious about the consequences of non-compliance with one senior manager stating that “we don’t dare to miss risk management [and] that is why I am in trouble with CAT²⁴ again” (Senior Manager 6, Wellington).

All of these institutional arrangements defended themselves against disruption by reining in the activities of the community organisations. Participants believed these strategies, including the withholding of funds and resources, were deployed to undermine the NGOs particularly when they were offering alternative, innovative services.

Being funded to fail: Where does all the money go?

Creating an uncertain funding environment worked as a defensive institutional strategy because it interfered with strategic service and organisational development. A senior manager from Wellington described how difficult it was to get information about future planning from DHB portfolio holders and believed this was another strategy of control over the NGOs. He noted that their DHB CEO, “openly says he is not into that stuff . . . planning,

²⁴ CAT refers to the Crisis Assessment Team of Adult Mental Health Services within the DHB

strategic planning, consultation, he openly says those things. Every [other] voice has [therefore] been disempowered” (Senior Manager 5, Wellington).

Several participants discussed DHB expectations being increasingly difficult to manage and some believed they were being “funded to fail” (Team Leader 5, Focus Group A, Hamilton). Many claimed their organisations were expected to provide more service with less resourcing, which inevitably squeezed frontline services and restricted the activities most participants and service users believed were priorities. A senior manager from Christchurch firmly believed that curtailing funding was also a serious block to organisational and sector transformation, interpreting messages from the DHB as, “You are not getting dumped, but you will never grow”. She went on to add that underfunding limited their capacity to retain good staff and that it was “hard to manage an extremely efficient effective service when wages are the thing that no-one will fund”. She concluded that for her organisation it was “a matter of accepting whatever the DHB can offer you and scrabbling around everywhere else for whatever else you can grab, and getting by, and underpaying fabulous staff” (Senior Manager 1, Christchurch).

Many, from throughout the country, reported that funding increases given to DHBs for cost of living adjustments, service establishment costs and other necessary administration were not being passed on, “leaving the NGOs significantly underfunded for providing the same services” (*Platform Trust*, 2008). The DHBs were also, typically, described as being “reluctant to give you enough money, enough to cover overheads; just” (Senior Manager 2, Wellington). A team leader from Hamilton, somewhat cynically, remarked the local DHB was “particularly conservative in how they dole out money for people; to anything that is not for them really” (Team Leader 3, Focus Group A, Hamilton). In similar vein, a team leader from Auckland commented that her “perception is that they will side with their colleagues if there is competition between a DHB to provide a service and an NGO” (Team Leader 1, Focus Group A, Auckland). All of which appeared to be tactics to strengthen and defend institutional power at the expense of the NGOs.

Many participants believed that, rather than service excellence and best practice being the basis for funding, organisations found themselves working “to their contracts in the sense that it was purely around the money, and not around the outcome” (Senior Manager 2, Hamilton). Several reported that the biggest impacts of budget constraints were on activities that enabled support workers to connect service users with their community. “I mean you can’t have an ordinary life if you can’t go to the beach, or go to the movies, or whatever it is that you want to do . . . You just can’t do these things that we take for granted” said one team leader (Team Leader 6, Focus Group H, Hamilton).

Funding inequities were galling for participants, especially because increases were not being directed to the community organisations but, invariably, “still going to the wards” (Support Worker 8, Focus Group A, Wellington). One support worker challenged the DHB to “get its arse down here to where the work is really done” (Support Worker 5, Focus Group A, Wellington) and participants were unequivocal that the work they did was significant, actively reduced the number of hospital admissions and saved the country millions of dollars.

Conclusion

Participants from the NGOs used a variety of strategies that challenged, problematised, and resisted institutional authority over their organisational environments and practices. However, these were variable in effect, mostly localised and displayed strong regional tendencies. In particular, the effectiveness of these strategies was determined by the quality of relationships that organisations had with their DHB clinical teams and funders. Even where effective relationships were apparent, it was evident that the NGOs expended considerably more energy and effort at maintaining these than did their DHB counterparts.

Social attitudes to institutionalised mental healthcare appeared to have changed over several decades, due in part to tensions between individualistic and social, or community, approaches. However, it was also apparent that

socially naturalised reproductions of biomedical and managerial power reinforced the normalisation of coercion, powerlessness, chronicity, and poverty for people with lived experience of serious psychological distress. Despite this, a growing resistance to professionalism was apparent that undermined institutionalised assumptions of medical benevolence, expertise and moral authority (Warriner, 2010).

Challenging the institutions and explicitly valorising recovery as national policy, meant validating and privileging the voices of service users in organisational planning and development. Intentional peer support teams, where these were contractually available were very effective but this growth appeared to have been at the expense of the NGO sector, which has continued to be underfunded and systematically devalued. This has seriously compromised their capacity to be innovative, in line with their constitutional values, and strategic in their long term organisational development of a recovery orientation.

The distinction between insider and outsider perspectives was apparent where participants from DHB backgrounds, while often providing knowledgeable and strategic leadership, seemed to do so at the expense of genuine organisational transformation and institutional disruption. These participants were more likely to express confidence in current change efforts and improvements rather than radical transformation. In contrast, service users and the community NGOs, as institutional outsiders, were clearly constrained by their financial vulnerability and dependency on the DHBs and were required to meet contracting expectations that frequently worked against their organisational values and conceptualisations of recovery.

Participants indicated that recovery outcomes, such as community participation, were routinely overridden by other agendas and a drive to reduce costs through rigid purchasing models inhibited innovation and strategic service development of the NGOs. The contracting power of the DHBs also exacerbated the chronic underfunding of the NGOs. DHB clinical services were invariably the largest service provider in their local area and it was inevitable, and perhaps

unsurprising, that the majority of DHB funding went to their own clinical and hospital services.

Discursive strategies such as translation, strategic ambiguity and discursive closure were seen to do generalised, institutional defensive work. Evidence from participants suggested considerable disillusionment with institutionalised translations of recovery that had infiltrated their organisational environments. These appeared to work against attempts to disrupt the institutions by diminishing the power of alternative discourses.

Particular strategies of defensive institutional work were also evident as the institutions of the DHBs reacted to challenges to their socially legitimised authority and defended themselves against institutional change and sector transformation. The institutions, particularly clinical services, positioned themselves as under threat and this had provoked a backlash against recovery itself as well as creating an uncertain, sometimes hostile environment for the NGOs. These defensive strategies increasingly devalued and discounted the NGOs. They could be overt and direct, like challenging the credibility and *reasonableness* of service users, support workers and community organisations, or strategically silent and dismissive. In addition contractual requirements that reduced the autonomy of the community organisations increasingly brought them back under a clinical umbrella also maintained institutional control.

In the Discussion chapter that follows, I summarise the findings in terms of their theoretical and practical implications for improving the credibility and legitimacy of community NGOs in the Aotearoa\New Zealand mental health sector. Specifically, I discuss how less powerful actors and groups, such as these organisations and people with lived experience of psychological distress, might act to resolve tensions at the discursive boundaries with powerful institutionalised groups. And, most importantly, how they might establish alternative discourses and practices in heavily institutionalised fields.

Chapter 9: Discussion and conclusion

*Reinvention is not changing what is, but creating what isn't.
A butterfly is not an improved caterpillar; a butterfly is a
different creature.*

Goss, Pascale and Athos (1993, p. 98)

Traditional mental health services are influenced by multiple, interacting factors from both within and beyond organisational boundaries; all of which may both enable and constrain the possibilities for organisational and institutional change. Critical and postmodern scholarship provided a rationale for utilising the framework of problematics for organisational communication research developed by Dennis Mumby and Cynthia Stohl (Mumby & Stohl, 1996, 2007). This framework enabled me to untangle the complex weave of interacting influences, and illuminate the institutional dynamics that are affecting the emerging identity and organisational transformation of the community NGO sector in Aotearoa\New Zealand, in terms of their intentions to become “recovery-oriented”. This approach was particularly important within the fields of health and mental healthcare where a socially normalised, scientific biomedical model has remained dominant in the organising of mental health care (Bracken & Thomas, 1999; Kecmanovic & Hadzi-Pavlovic, 2010; Pilgrim, 2007; Pilgrim & Rogers, 2003; John Read, 2005). It is significant that most critiques of these fields have occurred outside orthodox biomedicine and psychiatry.

Internationally, mental health systems and organisations have been undergoing significant reform for several decades (*see for example*, Ashton et al., 2005; Barker, 2003; Bel & Lindley, 2005; W. Brunton, 2004; Fisher, 1994a, 1994b; Jacobson & Curtis, 2000; S. Rose, 2000). The progress of this reform has been influenced, and sometimes constrained, by a complex inter-relationship of contributory factors, all of which have impacted on the everyday practices and organisational realities of the community organisations (Harrison, 2010; O’Hagan, 1999; Peters, 2009, 2010; Warriner, 2001, 2010). These factors have

included the introduction of a recovery philosophy that has worked in conjunction with growing civil and human rights movements throughout the Western world (Chamberlin, 1998; Mental Health Commission, 1998b; O'Hagan, 2009c; Jacob Read, 2003a; Warner, 2004). Alternative explanatory models, treatment responses and strategies for recovery from the impacts of serious psychological distress were articulated, and grounded in the narrative accounts of people with lived experience of extreme states of distress (see for example, Deegan, 1988, 1996; Leibrich, 2000; O'Hagan, 1998, 2004; Ridgeway, 2001).

The arguments presented here are not intended to be critical of biomedicine itself, nor even of fiscally responsible managerial practices. Many self-evident "goods" have come from biomedical science, even in mental health. However, what emerged clearly from the data was that the institutions cut a broad swathe and their socially normalised control over the organising of mental service delivery, strategy, and reform, had serious implications for service users and the community organisations. The culturally embedded biomedical model had naturalised most of our beliefs about health, illness, treatment and individual responsibilities for health. As a result, the discursive rules for talking about mental "illness" were constructed so that some possibilities for treatment responses and outcomes were realised rather than others, and those tended to ignore the circumstantial determinants of well-being and wider social change.

Recovery, on the other hand, emphasised the community aspects of well-being and challenged inequitable, individualistic approaches to the kinds of social organisation inherent in Western capitalist societies. The NGOs have thus been caught in a space between conflicting sets of values and have had to constantly negotiate the boundaries between them.

In this chapter, I first discuss the findings and analysis with specific reference to the implementation of a recovery-orientation in the mental health organisations of Aotearoa\New Zealand. The findings demonstrated various efforts to challenge social and institutional norms and shift the boundaries that defined sector relationships and the rules of engagement in mental health services. I then show how socially normative rationalities underpin institutional

resistance to change, despite legislative reform in the mental health sector. This was illustrative of barriers to institutional change, where the misalignment of one or more of the institutional pillars is insufficient, in itself, to transform organisational arrangements and behaviour.

I then outline the more general and important practical, theoretical and methodological implications that grow out of this analysis. Specifically, the thesis highlights the processes of institutional persistence and change that are crucial for understanding, not only the abandonment of existing discourses and practices, but also for the establishment of alternative models (Maguire & Hardy, 2009; Reay & Hinings, 2005). The thesis provides two major theoretical contributions. First, it extends the conversation about how institutions engage in defensive work in the face of perceived threat and challenge (Maguire & Hardy, 2009). Second, it highlights the role of *translation*, as a discursive strategy, in doing defensive institutional work. I then briefly discuss some of the limitations of this research to date and finally suggest some future pathways for further research and sector change.

Discussion of findings

The framework of problematics provided an anchor for a critique of the variety of issues underpinning the tensions between established and emerging discourses in the Aotearoa\New Zealand mental health sector, as well as their relationships with each other. A wide range of influences has woven the backdrop to contemporary mental health organisations and the literature review and background examined the major political, social and cultural precedents and contexts from which the mental health system has emerged. The treatment of madness has always been peculiarly vulnerable to political, ideological and socio-economic circumstances and there have been inevitable tensions among the social control function of mental health services, therapeutic care and individual human rights.

Organising recovery in the community sector of Aotearoa\New Zealand mental health services

My first research question was primarily associated with the problematics of voice and organising (Mumby & Stohl, 1996, 2007). Here, I examined the discursive distinctions between participant groups, their organisations and the wider sector environment as they constructed key concepts. The findings showed multiple constructions of significant terms such as madness, recovery, community life and what it meant to be a recovery-oriented organisation in the Aotearoa\New Zealand mental health system.

The findings echoed recent claims and arguments from the literature, some authored by people with their own experiences of serious psychological distress, concerned with the issues of voice, identity and representation. They were indicative of marginalised groups who struggled to reclaim the language, and control the meaning systems, of their experiences (Ashcraft & Pacanowsky, 1996; Cheney et al., 2004; Harter et al., 2010; Holmer-Nadesan, 1996; Maguire & Hardy, 2009; Mumby & Stohl, 1996, 2007). A lack of voice, valued identity and effective representation seriously limited the opportunities and choices for people even to envisage a meaningful and satisfying life (Harter et al., 2006). Some of these issues were a result of long-standing stigma, discrimination, and marginalisation but much was also clearly due to the impacts of the mental health system itself. All of this has led to mental health service users inhabiting a narrow world of limited options and a systemic lack of personal power.

It was evident that, despite being mandated in policy reforms and service descriptions, the language of recovery was being assimilated into other discourses; rather than becoming a powerfully constructed and effective alternative paradigm guiding service development, policy and practice. For people with lived experience of serious psychological distress, the language of recovery was continuously evolving, in response to the appropriation of their discourse by other stakeholders and interest groups.

The conceptual dissonance among participants made it clear that no single, authentic or shared discourse of recovery exists; but rather, there

remained a discrete set of common vocabularies and a beguiling fiction that “we’re all talking about the same thing” (Senior Manager 3, Auckland). The fiction of a singular concept was maintained in the transactions between interest groups, in order to negotiate and function across organisational boundaries, but in fact was translated in multiple discourses. Therefore, it was fulfilling an integrationist, rather than a change function (Mumby, 1988) in mental health sector reform.

The theoretical lens of translation was used to examine the implications of multiple meanings, conflicts and tensions in the language and concepts utilised by participants, as they negotiated multiple discourses and managed the transfer of ideas across organisational boundaries and throughout their organisational interactions (Cooren, 2001; Maguire & Hardy, 2009; Venuti, 2004). Translations of important constructs reinforced indications that there was still a significant gap between the expectations of service users for their recovery and what currently takes place in mental health services.

Translations of recovery were not random, but emerged from the ontological and epistemological assumptions of interest groups regarding the reification of mental illness or, conversely, constructions of madness. Institutionalised translation was evident in constructions of recovery as measurable progress through mental health services, beginning at service access and expedited towards discharge. This translation, common among participants who did not have their own experiences of serious psychological distress, limited a person’s “history” to the narrow biomedical account. They also revealed discursively complex notions of community care and a marked contrast between aspirations of living an ordinary life in community and being fit for society. Despite the rhetoric that mental health services exist to benefit a person’s aspirations and well-being, there was no rich sense of the lived experience of community and, pragmatically, the needs, priorities and interests of service users struggled in the face of more powerful voices and interests.

There were well-defined, if unarticulated, limits to being a recovery-oriented organisation, despite a general assumption that Aotearoa\New Zealand

mental health services were already recovery oriented. National policy and strategy texts tended to treat generic mental health services discursively, and unproblematically, as a homogenous set of organisations (Ministry of Health, 2005, 2006). This seemed to be an example of strategic ambiguity and had the effect of attributing broad recovery aims, such as service choice and *living well in community* to all mental health organisations, including clinical services. The co-existence of multiple meanings made communication across organisational boundaries possible. However, invariably, the resultant ambiguity supported the interests of dominant discourses and stakeholders by offering the appearance of change without altering relationships of power and dependence. Biomedical and managerial translations of recovery remained dominant, and discourses based on the subjective experiences of distress and recovery were clearly not embedded in organisational practices.

It was generally agreed that a recovery orientation in the configuration of mental health service organisations would look very different from traditional arrangements that prioritised clinical treatments and narrowly defined outcomes. The community organisations had a will towards a recovery orientation and most had endeavoured to embed recovery values, such as self-determination and full community participation, into their organisational systems, structures and service delivery. However, they struggled to establish credibility and legitimacy, and it was clear that their best intentions were severely hampered by other stakeholders. In particular, the institutionalisation of the bio-medical model as received truth still determined the orthodoxy in services, directed and dominated research, and controlled policy and strategy in the organisation of mental health systems.

Reforming the sector: Resistance and persistence

The second analysis chapter addressed my second research question. Here, I moved beyond discursive distinctions of recovery and was concerned with how the community NGOs managed within the wider sector and socio-political environment. Therefore, it was mostly concerned with the problematics of organising, the relationships among mental health organisations and society

and the underpinning rationalities of normalised organisational communication and behaviour (Mumby & Stohl, 1996, 2007). In this chapter, I examined the complex arrangements of institutional power evident in the Aotearoa\New Zealand mental health sector and the implications this has for their persistence and legitimacy; as well as exploring their influence over less authoritative discourses such as recovery in the organisational practices of community NGOs.

The mental health sector continued to be subject to biomedical and managerial institutional pressures as the operational arms of wider ideological, political and social forces. In particular, it was apparent that the interactions of the three institutional pillars - normative, cognitive and regulatory- (Maguire & Hardy, 2009) influenced, and impacted on, the participants, the community organisations and their practices around recovery as well as their relationships with other, more powerful, organisations such as the DHBs. In addition, organisational missions and values were frequently in conflict with, and regularly superseded by, clinical priorities and managerial imperatives. This meant there had been little practical change in outcomes for service users and no change in asymmetrical institutional relationships of power.

It was clear that disrupting the social legitimacy of the biomedical paradigm was especially difficult. This illustrated the problematic of rationality (Mumby & Stohl, 1996, 2007) which is concerned with what seems *reasonable* within particular paradigmatic, social and historical circumstances. What is logically coherent in a social system is necessarily inextricable from the discourses and practices that have shaped that social reality. Therefore, the discourses of madness and the medical model were socially naturalised and bound ideo-politically, meaning that new paradigms were inevitably less credible and framed as *alternative* to the dominant and orthodox bases of knowledge and expertise.

Normative power was evident when participants made ubiquitous, incidental references to biomedical and managerial authority in their organisational lives yet did not appear to be aware of key features of institutional arrangements. Institutional practices and knowledge bases were

naturalised and taken for granted even though participants simultaneously resisted this dominance. Despite expressing frustration with local clinical teams and funders, participants did not usually challenge the actual premises on which these institutionalised relationships were based. This reinforced the sense that participants and the lay public did not fully understand the complex interactions among the structural and discursive features of institutions (Coleborne & McKinnon, 2006; Johns, 2010; Warriner, 2010). Therefore, they tended to express their many frustrations and issues as local and idiosyncratic rather than systemic and institutional.

Recovery discourses had clearly not been effective in deinstitutionalising biomedical and managerial norms despite widespread assumptions about the historical deinstitutionalisation of mental health services in Aotearoa\New Zealand and other Western nations (W. Brunton, 2001; Joseph & Kearns, 1996, 1999; Leonard, 1999; Sawyer, 2005; Warriner, 2010). Treating the institutions as features of the past effectively created discursive closure around both biomedicine and managerialism as powerful, institutional drivers of organisations in the present. Discursive closure was also evident in the related assumption that mental health organisations in Aotearoa\New Zealand were already recovery-oriented. Similarly, expedient and strategic use of multiple discourses by institutional stakeholders also obscured significant differences among the sector organisations; with no space for the kind of engagement and debates about fundamental philosophies and values that Rob Warriner (2001, 2010), among other sector commentators has called for.

The NGOs were vulnerable to shifts in the socio-political environment that have been typical of the mental health sector over time (W. Brunton, 2001, 2005). Socio-political arrangements facilitated the adoption of recovery into mental health policy but the legislative changes that ushered in the DHBs effectively nullified its implementation and restored the traditional power of clinical services. This demonstrated that it takes more than misalignment of one institutional pillar to establish a new paradigm and ensure its stability.

Organisational transformation or service improvement?

The third analysis chapter answered my third research question, and was primarily informed by the problematics of organising and organising and the state (Mumby & Stohl, 1996, 2007) and their inter-woven relationships. Institutional parameters still seemed to be inordinately powerful in determining the nature and quality of service delivery in the sector and a lack of substantive change in mental health services had created considerable disillusionment. Discursive strategies such as translation, strategic ambiguity and discursive closure could be seen to do defensive institutional work and thwarted attempts to disrupt the institutions by diminishing the power of alternative discourses. In response, therefore, many service users in the sector were now endeavouring to move the discourse away from recovery towards a health promotion model of well-being (Ganesh & McAllum, 2010; Mental Health Commission, 2012a, 2012b; Sointu, 2005, 2006)

The chapter explored how participants endeavoured to problematise and disrupt institutional constraints, and highlighted the extent to which these attempts were effective. It also looked at stories of innovation, successful outcomes and how NGOs were engaged in organisational transformation and recovery orientated organisational change. The community NGOs were ideally positioned for supporting recovery aspirations, meaningful lives and community participation, and these ideals were the bases of how participants spoke of their role. They could readily articulate best practices and what constituted successful recovery outcomes, but were clearly frustrated in their attempts to introduce and establish innovative practices and strategies.

Strategies for innovation in the sector were variable in effect, mostly localised and depended heavily on the quality of relationships that organisations had with their DHB clinical teams and funders. This created a form of personality politics that many felt compelled to engage in, especially senior managers, but which frequently worked against their organisational values and conceptualisations of recovery. Such grace and favour relationships disguised institutional power to some extent. Even where effective relationships were

established these were clearly not systemic, relying instead on the stance of individual clinicians and the persistence and energy of the NGOs. The NGOs expended a lot of effort to appear non-threatening and conciliatory in managing organisational relationships at the borders with DHB clinical and funding teams. There was little evidence, however, that this occurred in the opposite direction.

Institutional logics governed the communication of discourses and ideas across organisational boundaries that, in turn, governed everyday organisational practices. The many costs for non-compliance were evidence of regulatory institutional pressures and posed serious risks to the viability of NGOs. Participants discussed several instances of “iron fists in velvet gloves” that reinforced the subordinate position of the NGOs and provided further evidence of hierarchical, institutional relationships.

Participants and their organisations problematised and challenged institutional power but mostly in local, situated ways. National network organisations endeavoured to provide more coordinated strategies and responses; however, these too were variable in effect. Over time, various organisational initiatives to establish innovation and a recovery orientation were attempted; but these were constrained in important ways, tended to be isolated instances and most had struggled to become established. A growing resistance to “professionalism” was also evident, and this undermined institutionalised assumptions of medical benevolence and moral authority.

Maguire and Hardy (2009) refer to two distinct forms of institutional change efforts as insider and outsider initiated. Both were evident in the data. Typically, insider attempts provide the appearance of change, commonly described as *restructuring* as opposed to *re-construction* or organisational transformation (Maguire & Hardy, 2009). Insider participants, typically senior managers or CEOs, often provided knowledgeable and strategic leadership, but at the expense of genuine institutional disruption. These participants tended to adopt, or “colonise” (Barker, 2003; O’Hagan, 2009a; Wallcraft, 2009), the institutionally translated vocabulary of recovery and accept the lack of substantive change in systems and practices. They, perhaps inevitably, seemed

more concerned with organisational viability and survival. These participants were also more likely to express confidence in current change efforts and service improvements.

Outsiders, on the other hand, are typically less powerful groups who are disadvantaged by the status quo (Maguire & Hardy, 2009). They are, therefore, personally invested in systemic change, and they have everything to gain by organisational and institutional transformation (Maguire & Hardy, 2009). The effectiveness of outsider change efforts depends on their power and capacity to disrupt one or more institutional pillars, and in the face of defensive institutional work. People with lived experience of serious psychological distress, and to a lesser extent support workers and the NGO sector in general, were outsiders to Aotearoa\New Zealand mental health services and framed their roles and organisational identities very differently from clinical services. These groups clearly had the most to gain by destabilising institutionalised discourses and practices.

These outsiders sought to establish new organisational identities and subject positions in order to challenge current organisational arrangements and practices. But, as with any social institution, only a limited number of subject positions are understood as meaningful, legitimate, and powerful (Hardy et al., 2005). The challenge for new subject positions, and actors, to emerge is not only to problematise aspects of the prevailing discourse but also to endeavour to understand what is blocking expression of an alternative paradigm. Emerging perspectives necessarily engage with, and constructed with reference to, the extant social contexts and dominant discourses. So, while outsiders articulated and valorised different perspectives, voices and subject positions, they had difficulty finding allies who were not compromised, or challenged, by that prospective change. This highlighted institutional reliance on the normative pillar that, in turn, validated the cognitive and rational bases of institutional authority. This was apparent even where legislative changes, such as the adoption of recovery into national policy had appeared to drive change.

In this research, I have made an important, although not rigid, distinction between generalised and particularised defensive institutional work. It was evident that the institutions were engaging in institutional work that defended them against perceived threats and challenge. It was also apparent that the establishment of the DHBs in 2000 had been a significant environmental change that reasserted institutional authority against which the alternative paradigm of recovery struggled to gain traction. All of these barriers were indicative of particular defensive institutional work, and typical responses to perceived threats when alternative discourses and actors arise to challenge, disrupt or destabilise institutional practices. Many of these strategies acted to devalue and discount the NGOs as outsiders. They could be overt and direct, like challenging the credibility and *reasonableness* of service users, support workers and community organisations; or they could be strategically silent and dismissive.

Translation was an important discursive strategy, central to the success of generalised institutional defensiveness. It ensured the maintenance of institutional authority, the recomposition of institutional stability, and the persistence of status, power and legitimacy of its agents. Despite legislative change and policy frameworks that mandated alternative approaches, such as recovery, translation ensured there was no diminution of institutional power in the relationships among organisations, the institutions and the state.

Institutional stakeholders, especially clinical services, often positioned themselves as embattled, or under threat from recovery and other alternative ways of thinking. This had provoked a backlash against recovery itself, as well as creating an uncertain and sometimes hostile environment for the NGOs. The findings corroborated recent literature (Ashton et al., 2005; Davidson et al., 2007; Duncan et al., 2004; Fakhoury & Priebe, 2007; Jureidini, 2012; O'Hagan, 2009a, O'Hagan et al., 2012; Warriner, 2010) and highlighted the same on-going issues and lack of real progress in mental health sector reform.

Overall, participants reported considerable disillusionment with the institutionalised translations of recovery that had infiltrated their organisational environments and diminished the power of alternative discourses of recovery. In

addition, seemingly incompatible meanings coexisted in organisational life and perhaps explained why, for many, recovery had become a tired and passé concept, and why a conscious and deliberate strategy has emerged, to move the focus away from recovery, compromised by institutionalised biomedicine, in favour of the more “living” discourses of individual and community well-being.

Combining theoretical understandings of both *translation* and *defensive institutional work* within a critical approach to organisational change offers insights into how biomedical and managerial power are operationalised over a whole organisational field, while acting also as mechanisms for social control. This may also go part way to explaining why recovery, as a locally emergent discourse, has struggled to become established. Therefore, the foremost contribution of this analysis to the organising of the mental health sector in Aotearoa\New Zealand is facilitating a deeper understanding of the complex features of institutions, and the dynamics of their persistence so that institutional disruption might be directed more effectively and systematically, rather than locally and in isolation.

However, this situation and circumstance is an exemplar of more general issues that face marginalised groups as they struggle for voice, and how alternative discourses and paradigms might become established in the face of socially normalised and institutionally powerful logics and practices. In the next section, I outline the general theoretical and methodological contributions this thesis makes to the field of organisational communication.

Implications: Practical, theoretical and methodological

This thesis offers three major contributions to scholarship in organisational communication. First, it adds to our understanding of the complex features of institutions and how, through the interactions of their institutional pillars, these establish, and maintain, authority over an organisational field. Particularly, it adds to the small body of research that examines processes of institutional disruption, and the inherent difficulties in destabilising institutional logics and introducing alternative discourses and

practices into institutionalised fields (Clemente & Roulet, 2015; Maguire & Hardy, 2009; Sullivan, 1992).

Second, it makes a theoretical contribution to the exploration of institutional defensive work and the impacts this has for potential institutional change agents, especially outsiders to an institutional field (Lawrence, Leca & Zilber, 2013; Lounsbury, 2009; Maguire & Hardy, 2009). Third, the thesis extends scholarly understanding of *translation* as a defensive institutional strategy (Venuti, 2004; Zilber, 2002, 2006). This has significance for many groups struggling to introduce new paradigms who find that, despite apparent language shifts, there is no substantive change in the institutional environment. It illuminates how the appropriation of others' conceptual worldview contributes to the erosion of alternative discourses and the disillusionment of the discourse communities for whom they have most significance (Barker, 2003; O'Hagan, 2009a; Wallcraft, 2009). A more detailed discussion of these contributions follows.

Institutions are established, discursively, as socially legitimate largely through the power and longevity of their historical traditions, relationships and norms (Lok & Willmott, 2006; Phillips et al., 2004). They are then naturalised by communities and societies, who devolve a great deal of responsibility and authority to institutional agents. New discourses and conceptual models disseminate throughout organisational fields in ways that never faithfully reproduce their original meanings. These findings, then, hold important implications for the capacities of less powerful individuals, groups and organisations to disrupt and destabilise institutional practices in order to establish alternative discourses.

Mutually beneficial relationships with the state, through government ministries and other policy makers, also sanction institutional capacities to normalise social attitudes and naturalise particular rationalities, which, in turn, enabled hegemonic control over organisational discourses and behaviour. These capacities also explained the power of institutional discourses to exclude, limit

and restrict ways of talking about and constructing knowledge about key concepts in a field.

Scholars have generally been more concerned with the ways in which institutions are maintained and reproduced; rather than the means by which they can be, challenged, disrupted and ultimately deinstitutionalised (Maguire & Hardy, 2009; Mumby, 1988; Reay & Hinings, 2005). The complex nature of institutions, the power, coherence and persistence of their bodies of knowledge and hierarchical structures, have also limited their capacity for critical self-reflection and reduced institutional and professional accountability for “failure”. The result has been enduring tension at the discursive boundaries of powerful institutionalised groups and less powerful actors and organisations, such as the community NGOs and people with lived experience of serious psychological distress.

A critical approach also illustrated the role of institutions in doing the work of ideological and political systems. The institutional pillars of biomedicine, such as managerialism, strengthened through their historical social contexts and symbiotic relationships with other ratio-scientific institutions, have created a web of power in the mental health sector that has successfully resisted change and absorbed alternative discourses. Critical examination of institutional processes helps to explain the mechanisms by which their social legitimation has continued to control organisational discourse and practices.

The findings of this research contribute to critical institutional theory, and specifically to the understanding of institutional disruption (Clemente & Roulet, 2015; Fakhoury & Priebe, 2002, 2007; Maguire & Hardy, 2009; Oliver, 1992). They demonstrated the inherent difficulties of introducing new paradigms because institutions have a unique social potency that is upheld by the status quo. Institutional pressures have ensured the conformity of individual organisations and have been the major barrier to organisational transformation (DiMaggio & Powell, 1983, 1991; Frumkin & Galaskiewicz, 2004; Mizruchi & Fein, 1999).

Institutional change is possible, if difficult, by the misalignment of one or more of the three, cognitive, normative or regulatory institutional pillars. However, reconciling large scale, social and institutional forces with individual and organisational capacities to act in particular ways is inevitably problematic. It takes more than disruption to the discourse to embed new logics and paradigms, and thereby organisational practices. Old institutional logics continue to influence the structural and material institutional arrangements, even if the coherence of discourses is disrupted (Reay & Hinings, 2005).

The thesis also supports a currently small body of research and provides evidence of institutional persistence through various strategies of defensive work, undertaken by institutions to counter perceived challenges to their power, legitimacy and authority. The analysis extends the work of Maguire and Hardy (2009), who investigated the deinstitutionalisation of DDT following publication of the book *The Silent Spring* (Carson, 1962), and examines the less successful efforts to deinstitutionalise the Aotearoa\New Zealand mental health sector and establish an alternative paradigm of recovery.

Socially marginalised, and less powerful, groups have habitually struggled to maintain control of their emerging discourses and resist the appropriation of key concepts by powerful, privileged groups. For example, this has been particularly difficult in the mental health field where there has been a sustained, clinical backlash against recovery. Among their objections have been claims that recovery is just a fad that sets people up for failure; that professionals have already been doing recovery for decades; that recovery-oriented care adds to the professional burden (Davidson et al., 2005). Trying to introduce new ways of conceptualising the world of their experience has been especially frustrating for socially marginalised groups when they have felt control of their discourse slipping away from them, not always through overt challenges but insidiously, through multiple translations by more dominant institutionalised discourses. No matter how persuasive less powerful groups were, nor how concerned they were to manage the meanings of concepts and practices they struggled to control the ways that others translated the discourse.

Several areas appear to be under-researched and, in particular, there have been few investigations into how institutional discourses and organisational practices might be disrupted, or destabilised, and alternative discourses and explanatory models introduced (Maguire & Hardy, 2009). Importantly, little scholarly attention has been directed to how institutions engage in defensive institutional work to preserve and protect their status and authority, and the mechanisms and strategies by which they respond to perceived challenge and threat. This thesis, therefore, has provided a contribution to this scholarship, particularly through investigation of the role of translation as institutional defensive work and the effect this has on emerging discourses and their discourse communities (Clemente & Roulet, 2015; Maguire & Hardy, 2009; Zilber, 2006).

At the boundaries between discourse communities, there is often no language of correspondence to represent, adequately or faithfully, concepts from another paradigm. Therefore, the translation metaphor, rather than a diffusion model, more accurately depicts the negotiated interactions between individuals and groups in asymmetrical power relationships (A. Brown, 2004; S. Brown, 2002; Chavez, 2009; Cooren, 2001; Ganesh, 2010; Maguire & Hardy, 2009; Zilber, 2006). Translation enables dominant groups, embedded in institutional cultures, to resist disruption, maintain control of institutional knowledge, and keep arrangements of power intact, and offers the appearance of change while masking institutional intransigence. As the processes of institutional disruption and institutional defence interact, and marginalised groups struggled to maintain control of their discourse, powerful groups often reject, and reframe as obsolete, their own translated discourses.

The first line of institutional defence work has been reliant on the punitive consequences that non-compliance brings with it, particularly the control of resources and funding. However, as the data shows, equally important “costs” are reductions in organisational legitimacy and credibility.

The third contribution of this thesis is methodological. Consideration of this form of a critically appreciative *fono* approach underlines the problematic of

voice (Maguire & Hardy, 2009) and exemplifies Freire's concept of conscientisation, which explicitly engages with the issues of dialogue, power and praxis (Freire, 1970). His model of empowerment, through creating spaces for shared understandings, not only enabled participants to feel significant as organisational members and workers, but also actively enhanced their sense of agency, thereby illuminating pathways for organisational transformation and encouraging future action.

The *fono* composition of focus groups, in cohorts of peers, removed power asymmetries and created opportunities for educational authentication (Lincoln and Guba, 1986) in the form of dialogic reflection among participants; workers who held deep knowledge about their organisations and experiences, yet who were typically outsiders to biomedical and managerial orthodoxies, marginalised, and/or treated as inconsequential. "Naming" their world (Freire, 1970, p. 69) through dialogue encouraged critical reflection and enabled people to discover the ways in which they were, in fact "situated". Together, they created shared understandings of their common circumstances and recognised how they had come to accept, or at least tolerate, their own subordination.

In the collaborative *fono* space, among their peers, participants were freely able to challenge the dominant, preferred stories, expose privileged perspectives and articulate other ways of organising the Aotearoa\New Zealand mental health sector. Specifically, through critical appreciation these participants were able to envisage preferred futures and potential pathways to organisational transformation and strategic sector development. It is in this sense, then, that critical and appreciative approaches come together in a conjunction of research as advocacy.

These processes raise issues of identity, marginalisation and naturalised rules about who can legitimately construct organisational and social knowledge within organisational and social systems. Barge and Oliver (2003) have suggested that becoming appreciative, in terms of organisational and management practices, means taking account of what others within the organisation value gaining a deeper *appreciative* understanding of the

organisation, its stakeholders and the multiple social, cultural, political and economic factors that influence its growth and development. Therefore, a key tenet of my critically appreciative inquiry was important for validating and privileging the voices of less powerful groups, including people with lived experience of serious psychological distress. Encouraging participants to share the stories, practices and ideals of recovery that excited them, and that were already working well in their organisations uncovered alternative, and potentially transformative, ways of conceptualising organisational practices, identities and niche.

The appreciative process enabled participants, typically outsiders to organisational development and strategy processes, to envisage preferred futures, challenge the dominant, preferred stories in the mental health sector and expose privileged perspectives.

Thus, a critically appreciative methodology has important implications for convening future sector forums and encouraging conversations about fundamental philosophies, the forces that promote transformation as well as the barriers to change. A focus on what positive, organisational transformation could look like could then become naturally embedded in current best practices and usefully connected to potential pathways and realistic strategies for organisational change.

Limitations

The limitations of this project were primarily concerned with the early assumption of the research design and methodological processes. As I explained in the Methodology chapter, I established the focus groups, expecting significant differences in the talk between cohorts at different levels within organisations; but these distinctions did not eventuate.

In addition, I made a conscious and deliberate decision initially, not to seek out directly the perspectives of people with lived experience of serious psychological distress. The first reason for this decision was primarily ethical. My stance was that people with lived experience of psychological distress had

clearly publicised what they needed from mental health service organisations through the authorship of a growing body of texts (see for example, *Central Potential*, 2008; Deegan, 1998; Leibrich, 2000; Mental Health Commission, 1998; O'Hagan, 1999; Pearson, 2000, 2001). Therefore, I intended to investigate how well the sector, generally, was representing their perspectives in everyday organisational communication and practice. Second, I knew that many people with lived experience of psychological distress also worked in the sector, and that service users and service user organisations would be naturally represented within the range of participants and the community organisations.

However, it was immediately apparent from the analysis that the voices and narratives of participants, with their own experiences of serious psychological distress, were significantly different from others in the sector. I therefore needed to extract meaningful comparisons from my data in ways that I had not anticipated. Fortunately, there were enough of these participants (29 of 131 participants), and the emergent themes so strong, that I am confident the comparative analysis, especially around *models of madness* and *stories of recovery* in the first analysis chapter, faithfully represents the organisational realities of the sector.

Comparing the language and talk of these participants with others then guided the analysis rather than my original assumption that the distinctions would be among the cohorts i.e. support workers, team leaders and senior managers. This distinction, however, did highlight the *insider* backgrounds of several senior managers and explained their approach to their strategic role as organisational leaders, responsible for organisational viability and survival.

What also seemed evident, and warrants further investigation, was the coherence of the talk among members of the *same* organisation. This proved counter-intuitive to my original assumptions of distinctions among participants with different roles and responsibilities. This suggests that the significance of the organisational communication of values, and their establishment in practice, is indicative of a clear articulation of organisational identity and faith in the organisational leadership. Such research might take the form of mini-case

studies of particular organisations and a fuller examination of the introduction of specific organisational innovations and eventual outcomes. Similarly, a longitudinal analysis of sector texts and policies over several decades could also produce rich insights about the interactions among normative, cognitive and legislative impacts on sector and institutional change over time.

Following where the data led, meant that I also deviated somewhat from the *active* aspects of action research and appreciative inquiry. This also detracted somewhat from my original intention of prioritising stories of success and innovation around a recovery-orientation in these organisations. However, the focus group and interview feedback forms indicated that participants had gained important insights, and a new appreciation, into their own organisations and the NGO sector in Aotearoa\New Zealand as a whole. It was also apparent from these that sharing their perspectives within the groups had facilitated new understandings that could lead to material change in organisational practices and potential transformation of the sector (Zorn et al., 2006)). In the event, there was neither time nor resources to return to participants and garner the changes they, or their organisations, had made in their organisational communications and practice.

In addition, the project generated such a plethora of rich data from just one round of data gathering that I needed to then be selective and pragmatic about what the analysis could realistically address. Therefore, the thesis has concerned itself with only the thematic and content aspects of the data, and fundamentally ignored the interactive data from the focus groups. I believe this will provide a rich mine of its own in future analysis.

Future directions and possibilities

Institutional logics and authority are difficult to disrupt. However, for many reasons it is often important to do so. While institutions offer stability, consistency and a degree of standardisation throughout an organisational field, which promotes confidence in stakeholders and wider society, they often do so at the expense of less socially powerful groups, organisations and communities.

Destabilisation, therefore, is important to stakeholders who are disadvantaged by the status quo; who want a voice and opportunities to influence the circumstances of their personal and organisational lives (Maguire & Hardy, 2009; Zilber, 2002, 2006).

Many issues underlying the mental health sector in Aotearoa\New Zealand need thorough exploration. Mental health services are not intended to be in a person's life forever. Therefore, it is important that the sector develop a profile of the person they expect to emerge from service involvement in their lives, and how this can be expressed effectively in organisational practice. In addition, the community organisations, particularly, need a clear articulation of their identity and a niche for the roles they perform. Transformation of the sector would also require the development of a strongly articulated, shared and visionary discourse of recovery or well-being if it were to survive translation by others. Institutionalising recovery would mean new organisational arrangements and a radical reconceptualisation of organisational roles and relationships.

In the particular situation of mental health organisations, these findings indicate many possibilities for further investigator and applied research. Mental health service leaders worldwide have called for the transformation of mental health systems. However, despite the appearances of change and reform, the same people with entrenched status, authority and power have tended to conceal and naturalise multiple contradictions and inequities, and have proved remarkably resistant to challenge and disruption. Therefore, the framework of problematics provides an important analytical tool for, and recognising institutional influences and barriers on, organisational change efforts.

The emergence of alternative systems of meaning, new voices, new subject positions and expectations of how organisations might enact different values and visions can enable a critical shift in social consciousness. Unfortunately, this alone does not inevitably lead to social action or substantive organisational change. Therefore, an increased understanding of defensive institutional work and the processes of translation would aid investigation of the degree to which alternative paradigms have penetrated and shifted institutional

pillars. For example it would be educative to examine how regulatory or legislative changes, shifts in social norms and rationalities have engendered particular responses (Maguire & Hardy, 2009). Additionally, and importantly, have these been merely discursive shifts rather than substantive organisational and institutional change.

There has been little scholarly attention, or funding, directed towards exploring alternative conceptualisations of psychological distress, because they have lacked social legitimacy. Authors with personal experiences of serious psychological distress have called for their own explanatory models of distress and recognition of their aspirations for social, political and organisational transformation. Therefore, research agenda and methodologies, other than quantitative positivism, need to be encouraged, and used to monitor changes in service development and practices.

These findings also have important implications, and further research is needed, for how less powerful actors, organisations and alternative discourses can become established in institutionalised fields in the face of defensive institutional work. The institutionalised fields of education, justice and Western systems of democratic government come immediately to mind. In addition, the ubiquitous encroachment of neoliberal logics and managerialism through the various processes of globalisation and the urgency of managing conflicting scientific claims in international responses to climate change, are worthy of future scrutiny. Critical examination of the ways that powerful groups defend their discourses through their use of discursive strategies such as translation, and thereby maintain their arrangements of power, is increasingly vital to social and human survival.

Generally, lay understandings of how institutional pillars operate to maintain institutional authority, has been poor (Di Maggio & Powell, 1983, 1991; Oliver, 1992; Maguire & Hardy, 2009). Their complex interactive features has made it hard to identify where resistance and challenges could be effective. This has meant that most change efforts have been local and situated rather than systemic and strategic. As Maguire & Hardy (2009) explain, this disruption needs

to occur synchronously on several fronts, specifically directed at the normative, cognitive and legislative pillars. This also has important implications for the introduction and establishment of new, alternative paradigms. Therefore, research that balances traditional institutional theory with more critical approaches would support people, organisations and communities to engage with and influence organisational evolution and change.

Further research is also needed to examine closely the dynamics of the relationships that the neoliberal logics of organising, embedded in biomedicine and managerialism, have with their social context and to challenge their narrow evidence base. Tensions abound in the struggle for control of the discursive spaces when it comes to notions of the “public good”, individual and social responsibilities for well-being as well as constructions of “the community” among others. Understanding the mechanisms by which personal, organisational and community agency is enabled or constrained is crucial. In particular, it would seem important to investigate how the community organisations might change their relationships with institutional and clinical organisations in ways that diminish their inherent asymmetry. Researchers would need to recognise and understand the processes of defensive institutional work, in order to understand and respond to inevitable institutional backlash.

In addition, unquestioned social legitimacy leads to a degree of institutional complacency. This has led to forms of change that are typical of *insider* reforms and organisational *improvement*, rather than a critical review of base assumptions and arrangements of power that might lead to re-construction. Thus, institutional insiders tend to employ various mechanisms to maintain their authority and seek their own survival at the expense of genuine transformation. These not only include costs for non-compliance to control organisational behaviour but other corrective mechanisms when one or more of the institutional pillars becomes misaligned. This has been evident in the mental health field, including the Aotearoa\New Zealand mental health sector, when clinical discourses of risk arose to counter discursive and legislative changes around the introduction of recovery (Sawyer, 2005). Other significant

mechanisms include the various generalised and specific institutional defensive work discussed in this thesis. Translation, in particular, as a defensive strategy, deserves more scholarly attention.

The discursive resources of various stakeholder groups would be a rich source of data for comparative analysis and longitudinal research using a methodological approach similar to that of Maguire and Hardy (2009). This would encourage more scholarly attention on new voices and subject positions, with reference to changes in language and discursive resources, and could usefully focus on how such shifts and translations are used to maintain institutional authority and powerbases. Future studies could pay particular attention to, and compare how the discursive resources stakeholders use and how they seek to position themselves and their organisations in institutional fields. It would be equally useful to examine relationships among discourse communities over time (Henderson et al., 2007; Maguire & Hardy, 2009; Weaver, 2010).

It would also be very educative to apply the framework of problematics (Mumby & Stohl, 1996, 2007) to explore how the institutional pillars interact to maintain social disadvantage. For example, critical investigations to scope larger issues such as the social and political representation of indigenous communities and the effects of dominant institutions such as the law, education and health on cultural identity, educational achievement and other indicators of social well-being. A cursory glance at the attempts of these and other communities show that discursive changes alone are insufficient to disrupt normative pillars and language changes in isolation risk being ridiculed as “politically correct”.

These frameworks would also be useful for macro analyses of other global issues and to examine relationships among the institutional pillars, particularly how legislation and regulation interacts with cognitive and socially normalised discourses and practices. An example might be the extent to which growing public alarm over climate change has led to adequate and substantive change in normalised rationalities and regulation, given the dominance of neo-

liberal economics and acceleration of the processes of globalisation (Cheney & Cloud, 2006; Ganesh et al., 2005; Thomas et al., 2005)

Organisational and institutional transformation is more than mere change. Transformation is the death of one way and the birth of another; it does not mean doing more of the same, or even doing the same things better (Adams et al., 2006). Equally, organisational transformation requires fundamental shifts in the rational bases of institutional logics and the enactment of new attitudes, values, and relationships in discourses and practices that connect to the social world in just and equitable arrangements.

Transforming organisational practice around recovery is a real and pragmatic issue for mental health services in Aotearoa\New Zealand. An effective NGO sector could be positioned as a significant subject position and model for a more genuinely recovery-oriented mental health sector. However, this would require a profound paradigm shift and a further wave of organisational transformation, which fully incorporated other voices and perspectives. Mary O'Hagan (2010), a prominent campaigner over several decades for sector reform in Aotearoa\New Zealand, recently commented, "We cannot create genuine change without transforming social and professional attitudes to madness". However, it is clear that, despite their best intentions, these organisations have struggled to enact a recovery philosophy that would realise their aspirations for organisational and sector transformation.

Appendix 1: Summaries of participant demographics

Table 1: Summary Participant Demographic Information

Summary of Participants	Numbers	Comment
Total Participants	131	The community mental health sector, like most social services is dominated by women especially in lower paid roles.
Male	40	
Female	91	
Identified as Service users	36	
Identified as Māori	16	
Regional Breakdown	SW²⁵\TL²⁶ FG²⁷ participants	Interview\SM²⁸ focus group
Auckland	27	5 (Interviews)
Waikato	50	6 (Interviews)
Wellington	19	6 (1 Interview, 5 Senior manager Focus Group)
Christchurch	15	3 (Interviews)

Table 2: Summary Support Worker participants

Support Worker participants	Numbers	Comments
Number of Focus groups	11	1 focus group was a designated Peer Support Team from 1 organisation in Auckland that included 2 Co-Team Leaders
Total No. Support workers	73	
Male	21	1 focus group in Christchurch was comprised of workers who also identified as having used mental health services. Three of these worked for a service user organisation; the other 3 for generic NGOs
Female	52	
Identified as Service users	26	
Identified as Māori \ (drew from a Māori perspective)	10	
Identified as “other” culture \ (drew on other cultural perspective)	4	
		In Auckland, there were 4 workers working for 3 organisations who were designated Asian\Indian support workers working within their cultural communities

²⁵ “SW ” is an abbreviation for “support worker ”

²⁶ “TL” is an abbreviation for “team Leader”

²⁷ “FG” is an abbreviation for “focus group”

²⁸ “SM” is an abbreviation for “senior manager”

Table 3: Summary Team Leader participants

Team Leader participants	Numbers	Comment
Number of Focus groups	10	3 Team Leaders had experience of working in DHB environment as nurses or social workers and were able to bring that comparative experience to the focus group.
Total No: Team Leaders	38	
Male	7	
Female	31	
Identified as Service users	5	
Identified as Māori	5	

Table 4: Summary Senior Manager participants

Senior Manager Participants	Numbers	Comment
Number of Interviews	16	1 Wellington organisation made their whole senior management team available and I was able to conduct a focus group with these 6 people, 2 of whom also identified as having used mental health services.
Number of Focus groups	1	
Total No. Senior Managers	20	
Male	12	
Female	8	1 senior manager of a small service user organisation in Hamilton participated in a focus group rather than be interviewed
Identified as Service users	5	
Identified as Māori	1	

Table 5: Summary Participant Organisations

Participant organisations	Numbers	Comment
Total No. Organisations	27	
Auckland	3	
Waikato	12	
Wellington	3	
Christchurch	9	
Designated Peer Support Team \ Peer Support workers	2	
Service user organisations	4	
Family support organisations	3	
Kaupapa Māori service team	4	
Kaupapa Māori organisation	1	

Table 6: Summary of Community Support Worker Focus Groups

Location	Focus group \ Interview	Composition	No of Participants
Auckland Central	Focus group Code: A	Single large organisation Mix male, female 1 designated Asian support worker 2 service user workers ²⁹	7
West Auckland	Focus group Code: B	2 large organisations Mix male, female 2 designated Asian workers	7
West Auckland Peer support Team	Focus Group Code: PS	1 organisation 2 team leaders & 6 peer support workers All peer support workers	8
Hamilton	Focus Group Code: A	4 organisations 1 CEO of small service user organisation	4
Hamilton	Focus Group Code: B	2 organisations 1 family support worker	2
Hamilton	Focus Group Code: C	4 organisations 2 of 6 designated kaupapa Māori workers 2 of 6 Family support workers	6
Hamilton	Focus Group Code: H	1 national organisation - home-based 1 male, 4 female	5
Hamilton	Focus Group Code: P	1 large organisation, urban, residential All female 1 Team Leader attended	7
Waikato (Thames \Waihi)	Focus Group Code: W	1 organisation All female 2 service user peer support workers	7
Wellington	Focus Group Code: A	1 large organisation Mixed Male and female 2 designated peer support workers	10
Christchurch	Focus group Code: A	3 organisations - 1 service user run 1 male & 4 female	5
Christchurch	Focus group Code: S (Service users)	3 organisations – 1 service user run Mixed male and female All service user peer support workers	5

²⁹ In other words, workers who also identified as having used mental health services

Table 7: Summary of Team Leader Focus Groups

Location	Focus group \ Interview	Composition	No of Participants
West Auckland	Focus group Code: A	2 organisations 1 male and 5 female	6
Hamilton	Focus group Code: P	1 national organisation: residential & home based community support	6
Hamilton	Focus group Code: A	4 organisations 1 service user organisation 2 service user workers 1 social worker now DHB	5
Hamilton	Focus group Code: H	1 national organisation Home based community support 2 female	2
Waikato (Thames\Waihi)	Focus group Code: W	1 national organisation All female	6
Wellington	Focus group Code: A	1 large organisation 1 male and 5 female 1 Kaupapa Māori worker	6
Wellington	Focus group Code: B	1 national organisation, 2 clinical team leaders	2
Christchurch	Focus group Code: A	5 organisations 1 service user organisation 1 peer support worker	5

Table 8: Summary of Senior Manager Focus Groups and Interviews

Location	Focus group \ Interview	Composition	No of Participants
West Auckland	Interview Code: 4 3 1	2 organisations 1 CEO large organisation ³⁰ 1 Senior Manager ³¹ 1 Service Manager ³² 1 male and 2 female	3
Central Auckland	Interview Code: 2 5	1 organisation 1 CEO organisation 1 Senior Manager 2 male	2
Hamilton	Interviews Code: 2 3, 4 1 5	5 organisations 1 CEO of a Kaupapa Māori org. 2 CEO, 1 service user organisation 1 Manager Family Support 1 Operations Manager service user organisation 1 service user organisation 1 Kaupapa Māori organisation 1 Family Support organisation 3 service users 1 Māori 2 male and 4 female	5
Wellington	Focus group Code: 2 3,4,5,6,7	1 large organisation 1 CEO 5 senior managers 3 SM also service users 3 male and 3 female	6
Wellington	Interview Code: 1	CEO head office national family support organisation	1
Christchurch	Interview Code: 1 3 2	3 organisations CEO service user organisation Regional Manager national org. CEO large organisation	3

³⁰ This CEO was **not** from the same organisation as the Senior Manager below

³¹ This interviewee was **not** from the same organisation as the CEO above

³² The Service Manager **was** from the same organisation as the CE above

Appendix 2: Focus group questions

Table 9: Focus Group Questions

<p>Introductory round, eliciting individual responses:</p> <p>Tell me about your role</p> <p>Focussing Question</p> <p>1. Tell me what recovery means to you? Is it important for a service to be recovery oriented? Why?</p> <p>What are the most important values underpinning these approaches?</p> <p>What do recovery and strengths-based practice mean to you in terms of relationships with service users?</p> <p>What do recovery and strengths-based practice mean to you in terms of outcomes for service users?</p> <p>What do you think “community participation” and “social inclusion” mean for service users?</p> <p>What does successful living, ordinary living mean for service users?</p> <p>Where should we put our best time, thought and energy in services if we want to help people develop a sense of ordinary life? What kinds of things should we be doing?</p> <p>What are the supports, structures, systems that enhance successful living?</p> <p>2. Tell me about recovery and strengths-based practice in your organisation</p> <p>How important is it in your organisation to be recovery oriented?</p> <p>What works well in your organisation in terms of recovery and/or strengths-based practice</p> <p>How is recovery and/or strengths-based practice communicated – how do people ‘know’ about it?</p> <p>What would be the best aspects of your organisation, from a service user perspective?</p> <p>What are the best possible outcomes for a service user in your organisation at present?</p> <p>How do aspects of the organisation express recovery and/or strengths-based practice?</p> <p>For example: Policies, Procedures, Organisational structure, Staffing, Training & professional development, Communications, Service specifications</p> <p>What is possible in your organisation? What kind of a difference can you make in people’s lives?</p> <p>What constrains this from happening? What is it difficult for your mental health service to consistently do well?</p> <p>3. Tell me about the wider environment and other stakeholders that impact on how your organisation is becoming recovery oriented and \or strengths-based practice</p> <p>Who are the other stakeholders that influence your organisation and its visions and values?</p> <p>What are the significant influences and relationships your organisation has with other stakeholders?</p> <p>How do these work? E.g. Community, DHB, Clinical services, Funders, Families, Other agencies</p> <p>What do you understand about the “medical model”? How do you think this model influences community services and organisations?</p> <p>How do you perceive the political or social landscape – have things changed? What impacts do political shifts have?</p> <p>What are the issues and influences facing your organisation trying to become recovery oriented or strengths-based? What supports? Constrains?</p>
--

Appendix 3: Pre-focus group participant forms

Realising Our Best Intentions: Vision, values and voice in community mental health organisations. PhD research project

Kirsty Barber barberk@mngt.waikato.ac.nz

Participant Information Form

Name		Code:	
Region		Cohort:	
Contact Details:			
Email			
Phone			
Mailing			

Consent Form		Agrees to recording		Identification	
--------------	--	---------------------	--	----------------	--

Organisation:
Address:
Organisation service description
Position held:
Role description:
Other\ previous roles in mental health sector
Organisations Mission, Vision and\or philosophy statement(s)

Organisational approach to (or position on) recovery				
To what extent does your own position \ practice of recovery correspond to your organisations?				
Conflicts	Some tension	Some agreement	Basically similar	Identical

Organisational approach to (or position on) strengths-based practices				
To what extent does your own position \ practice of strengths-based practice correspond to your organisations?				
Conflicts	Some tension	Some agreement	Basically similar	Identical

Appendix 4: Post-focus group participant forms

Realising Our Best Intentions: Vision, values and voice in community mental health organisations - PhD research project

Kirsty Barber barberk@mngt.waikato.ac.nz

Participant Feedback Form

Overall, what was your experience of this focus group?

Not useful	Not very worthwhile	Okay	Worthwhile	Very worthwhile

Please indicate three key messages or ideas that came through for you in the focus group

- 1.
- 2.
- 3.

Please comment below on the questions asked in the focus group

Overall, what was your experience of the questions asked				
Irrelevant and unimportant	Few relevant and important	Somewhat relevant & important	Most relevant and important	All relevant and important

Each main topic question is listed individually below, please comment as indicated

	Keep	Change	Leave
1. Tell me what recovery means to you?			
2. How are recovery and strengths-based practice “talked about”, expressed, communicated in your organisation?			
3. What would a recovery-oriented service be like?			
4. What do recovery and strengths-based practice mean in terms of outcomes for service users?			
5. What do you think would be an “ordinary life”?			
6. What do you think is “successful” living?			
7. What does strengths-based practice mean to you?			
8. What is “community participation” and “social inclusion”?			
9. What are the influences of the wider environment and other stakeholders in terms of recovery and strengths-based practice in your organisation?			

Other questions \ issues for discussion that would have been useful

--

Please comment below on the activities used in the focus group

Overall, what was your experience of the activities				
Irrelevant and unimportant	Few relevant and important	Some relevant and important	Most relevant and important	All relevant and important

Each activity is listed individually below, please comment as indicated

1. Scaling activity - Where your organisation is at in terms of recovery and \or SBP?	Keep	Change	Leave Out
---	-------------	---------------	------------------

	Yes	No
Has this process been useful to you in terms of understanding issues for developing recovery and strengths-based practice in community mental health organisations?		
Has your experience in this focus group changed or enhanced your thinking about recovery?		
Has your experience in this focus group changed or enhanced your thinking about strengths-based practice?		
Do you think this research is worthwhile in terms of the development of the community mental health NGO sector?		
Have you any suggestions to improve either the process or usefulness of this research project?		

--

Thank you again, noho ora mai, na Kirsty

Appendix 5: Textual data

Table 10: Important National and Sector Texts as data sources

Item	Publisher	Date	Utility and/or Themes
<i>Mental Health (Compulsory Assessment and Treatment) Act 1992</i>	Ministry of Health	1992	The Act formalised the definition of “mental disorder” and endeavoured to provide individual rights & protections
<i>Moving Forward: The national mental health plan for more and better services</i>	Mental Health Commission	1997	Strategic signal from newly formed Mental Health Commission also outlined terms of reference
<i>The Blueprint for Mental Health Services in New Zealand</i>	Mental Health Commission	1998	Set the benchmarks for “the way things should be” in Aotearoa\New Zealand mental health services
<i>Te Mahere O Nga Ara Haere: Map of the Journeys Towards Equality Respect & Rights for People who Experience Mental Illness</i>	Mental Health Commission	1998	Specific strategy for addresses stigma and discrimination; became the Like Minds, Like Mine campaign over time
<i>Communities and Government - Potential for Partnership Whakato-pu-Whakaaro.</i>	Ministry of Social Development	2001	Outlined and lobbied for the role and potential of non-government organisations & their relationship with government.
<i>National Plan 2003-05: Project to counter stigma and discrimination associated with mental illness</i>	Ministry of Health	2003	Government policy & funding endorsement of anti-discrimination & stigma campaign
<i>Te Tahuhu: Improving Mental Health 2005-2015: The 2nd NZ MH & Addiction Plan</i>	Ministry of Health	2005	Outlines government policy and priorities for mental health sector for 2005 to 2015. Explicitly links mental health to addiction.

Table 10: Important National and Sector Texts as data sources (cont.)

<i>Te Kokiri: The MH & Addiction Action Plan 2006–2015</i>	Ministry of Health	2006	Companion to <i>Te Tahuu</i> developed to directly guide implementation
<i>Te Haererenga mo te Whakaoranga: The Journey of recovery for the N Z Mental Health Sector, 1996-2006</i>	Mental Health Commission	2007	Chronicles the development of mental health services in Aotearoa\New Zealand 2005-2015
<i>Te Hononga 2015: Connecting for greater well-being</i>	Mental Health Commission	2007	A unifying picture of the sector in 2015 from MHC perspective focused on values & NZ society
<i>Te Awhiti: National Mental Health & Addictions Workforce Development Plan for, and in support of, Non-Government Organisations 2006-2009</i>	Ministry of Health\Health Research Council	2006	Makes the case for full NGO participation in sector development as legitimate and credible partners in the growth of mental health services in Aotearoa\New Zealand
<i>The Services we Need: Mental health service users' expectations for the future</i>	<i>Central Potential: Te Rito Maia</i>	2008	A “guide to systemic advocacy” by nationally recognised consortium of service users contracted by 6 DHBs through central North Island
<i>Destination recovery: Te Ūnga ki Uta: Te Oranga.</i>	Mental Health Advocacy Coalition (MHAC)	2008	Eclectic sector group formalised in 1994 to provide mental health sector perspectives and policy advice to the Ministry of Health
<i>Frontline: The community mental health and addiction sector at work in New Zealand</i>	<i>Platform Trust</i>	2010	NGO perspective on community organisations, innovations and recovery. Vignettes and rationale for sector.
<i>Recovery Meanings and Measures: a scan of the literature*</i>	Mental Health Commission	2011	Demonstrated some important “translations” from variety of perspectives within the sector

* Interestingly this document introduces the HONOS (Health of the Nation Outcomes scale but ends up evaluating a range of other, recovery specific, assessment tools. despite this it is HONOS that has been adopted into NZ mental health services

Appendix 6: Preliminary data from pre and post focus group forms

Table 11: Preliminary statistics from pre and post focus group forms

Item	(5 point Likert scale)	% response
The focus group or interview was . . .	‘very worthwhile’ (5 on scale)	50%
The focus group or interview was . . .	‘worthwhile’ (4 on scale)	48%
Issues discussed were . . .	‘all relevant and important’ (5 on scale)	49%
Issues discussed were . . .	‘mostly relevant and important’ (4 on scale)	44%
The process has been useful in terms of understanding issues for developing recovery and strengths-based practice in community mental health organisations	82 comments on process specific issues	92%
This research is worthwhile in terms of the development of the community mental health NGO sector	99 comments about community ngos and community support workers.	96%
The experience in this focus group changed or enhanced your thinking about recovery?	40 comments specific to importance of recovery	69%
The experience in this focus group changed or enhanced your thinking about strengths-based practice?	15 comments specific to strengths & strengths-based practice.*	68%

NB. It was very apparent from the conversations that participants subsumed a “strengths” approach under the umbrella of “recovery”. Those who were explicit about strengths sometimes meant the Strengths Model (Rapp et al., 1999; Weick et al., 1989; Sullivan, 1992) which has been formally adopted or endorsed by some organisations. A few others were aware of and drew from discourses of strengths-based practice (Barber, 2005; Saleeby, 2002; McCashen, 2005). However, several organisations had not been formally exposed to either of these discourses and given the other directions that the data was taking; I decided not to focus on strengths-based practice as a separate theme.

Appendix 7: Emergent themes

Table 12: Emergent Themes

<p>RQ 1: In what ways are discourses of recovery constructed, negotiated and resisted in within non-government community mental health organisations in Aotearoa\ New Zealand</p>	
<p>Emergent Themes</p>	<p>Notes</p>
<ol style="list-style-type: none"> 1. Stories of madness 2. Stories of recovery: The nature of journeys 3. Measuring progress and the outcomes of recovery 4. Recovery relationships and roles 5. Emerging discourses of recovery and well-being 6. Living in “community” or Being “fit” for society 	<p><i>Lost in translation:</i> 1st analysis chapter</p> <p>Participant talk compared & contrasted sector documents & service user literature.</p> <p>Privileged service user voices and the right to self-identify.</p>
<p>RQ 2: How are institutional dynamics working to construct, constrain or contradict organisational practices in terms of becoming “recovery –oriented”?</p>	
<ol style="list-style-type: none"> 1. Normal and natural; the “taken for granted” aspects of social assumptions & institutional discourses 2. The bad old days have gone: Myths of deinstitutionalisation 3. Enduring and persistent: Bodies of knowledge 4. Expertise and professionalism 5. Legitimation and authority: Asymmetry and relationships of power 	<p><i>Encountering the Institutions:</i> 2nd analysis chapter</p> <p>Sector documents, focus groups especially Peer support workers with respect to institutionalised injustice.</p> <p>Focus groups & organisational texts re contracting and funding</p> <p>Funders & clinical providers: “evidence based practices”</p>
<p>RQ 3: In what ways are institutional dynamics being problematised and challenged within the community non-government organisations and to what effect?</p>	
<ol style="list-style-type: none"> 1. Subordination and insubordination 2. Problematising: Undermining the institutional pillars 3. Struggling to disrupt: insiders and outsiders taking on the institutions 4. Where does all the money go: The rise and rise of clinical services 5. “We just do it differently”: Clinical services versus the non-government organisations 6. The Empire strikes back: Counter challenges and defensive institutional work 	<p><i>Subordination & Insubordination:</i> 3rd analysis chapter</p> <p>Focus groups & Interviews</p> <p>Positioning the institutions as “embattled”</p> <p>Teaming up: Blurring the funder\provider boundary</p> <p>Managing multiple discourses</p> <p>“clinical oversight” & “risk aversion”</p>

Appendix 8: Initial impressions, preliminary findings and emerging themes

Initial impressions and participant feedback that guided the analysis

The early analysis and preliminary findings guided my substantive thematic analysis, and provided confirmation of the appropriateness of the inquiry methods and investigative direction. The collated summaries of the pre-focus group\ interview forms and post- focus group\interview feedback forms (Appendices 6 & 7) showed commonalities among language use and the identified key messages provided an initial sense of the variance among participants. Similarly, the quantitative aspects of this data allowed me to gauge some initial, and general, inferences about the issues that mattered most to participants and the overall worth of the project to them. The results of this brief analysis are displayed in Appendices 6 and 7.

Participants were invited to make additional comments on their post-focus group forms and the collation of these revealed some interesting features. Over half chose to comment on how the focus group discussion had shifted their thinking in some way, with 69% indicating that their understanding of recovery had been enriched through the shared talk. Many appreciated the opportunity to see how other workers and organisations were faring and 47 explicitly referred to the value of having an open, safe and collaborative space in which to share thoughts and ideas; as well as recognising common challenges. Only one participant indicated that the focus group was “not worthwhile” and yet went on to state, along with 49% of participants that all the issues discussed were “relevant and important”. Another 15 participants commented directly on the importance of the project itself.

The second most important category for participants, inferred from the number of people who chose to comment on this, was the significance of the roles and niche of community support workers (49 comments) and the NGO sector as a whole (47 comments). Most of these comments referred to the importance of effective relationships with service users and the need to keep

pushing for a new paradigm in the sector by adopting a “whole of organisation” approach i.e. aiming for congruence between policies and practice. Eleven people referred directly to the importance of peer support in recovery work.

I compared language features, constructions and thematic patterns in the transcript data with this secondary data from pre and post focus group forms and data from the national and sector texts. From these comparisons, I discerned emergent themes (Appendix 7). The texts were interesting in that those not authored by service users, over time, had come to treat recovery-oriented mental health services as a given. Others such as *Destination recovery* (MHAC, 2008) and *Frontline* (Peters, 2010) provided local Aotearoa\New Zealand exemplars of visionary practice; but even these did not correspond with best practice service descriptions discussed in *Getting the Services We Need* (2008), and is a text authored by a service user organisation who were contracted by six DHBs in the central North Island. Similarly the dominant, or *preferred*, organisational stories expressed in most texts were not echoed in the focus groups and interviews. However, at this point, I needed to substantially reduce the size of the data set, and I eventually put aside further close analysis of these texts; instead using them mainly to position the discourses within the wider context of mental health services in Aotearoa\New Zealand.

Examination of the pre and post focus group forms to discern tensions, if any, among participants’ own values with their organisational values indicated that participant values were “identical” or “basically similar” to those of their organisations. This was the first signal that the most important issues faced by participants might be external to the organisations. This sense was reinforced by other comments that constructed a binary between DHB clinical services, as “them”, and “us”; a relationship that also created resource dependency and funding constraints. A total of 39 comments were directed at problems with funders, DHBs and contracting processes and the tension between community values and management ideology in particular.

With these initial impressions in mind, I continued re-reading the transcripts, noting other features that emerged. It was soon apparent that some

vocabularies were being used by participants in different ways, and had different meanings. I began to consider the uses of language and how to define linguistic boundaries and paraphrase common ideas (Aronson, 1994). It was clear that the major distinctions were not evident between cohorts, as I had anticipated, but were very apparent between DHB regions and organisations.

All of these observations helped to confirm that with such a rich data set, I could proceed meaningfully in several directions and that I needed to make some selection decisions. To that end, I then identified the major themes that stood out from the data and concentrated my focus on unpacking and analysing these across the focus groups and interviews.

Emergent themes and adjustments of the research questions

The initial thematic analysis exposed two powerful but somewhat surprising features. First, although I had not previously suspected that there would be such a remarkable distinction between “models of madness” (Read et al., 2004) and a reified construct of “mental illness”, this was clearly well known and taken for granted by participants with their own experiences of serious psychological distress. They talked about “madness” in very different terms from other participants. The second outstanding feature of the initial analysis was that when participants were asked directly to describe the medical model and its influence in mental health services, they seemed a bit non-plussed. Nevertheless, they continually referred to the impacts of “clinical” approaches as dominant, negative, controlling and “other” to what they were trying to achieve in their own organisations.

Therefore, it was apparent biomedicine, as an institution, was still prevalent in mental health services despite a national policy of recovery and a common assumption of “deinstitutionalisation” as historical fact. This drew my attention to the way participants and others conceptualised the institutions and most pertinently deinstitutionalisation. It became clear that participants perceived that institutions were merely physical buildings and locations, and, most importantly, that institutionalisation was a thing of the past (Warriner,

2010). This meant that some emerging themes were as interesting for what was not said as much as for what was.

The next stage of the analysis examined participants' use of language and metaphors such as "ordinary life", "people like us" and "clinical is different". The choice and variety of vocabulary, the frequency of word use, the intensity of delivery, as well as what was missing from the talk, led to tentative identification of important meanings and ideas. However, discursive strategies are broader than mere language features and the narratives that arose from the focus groups and interviews were inevitably shaped by their interactional features, in which contrasting versions of reality could be inferred from challenges and competing interpretations of what happened in organisational communication and practice.

Collating and exploring these narrative fragments, within their context and across transcripts exposed patterns of tacit discourse and hinted at subliminal assumptions and values sometimes at odds with the intent and overall sense of what was said consciously. It was also apparent that participant responses could be triggered by stimuli that elicited particular responses. For example, when asked to define recovery, many participants responded with stock phrases from *The Blueprint* (Mental Health Commission, 1998) such as recovery being a "journey" and the importance of "walking alongside people" which have almost become clichéd.

What was also striking was how people used the same vocabularies, especially around notions of recovery, but clearly meant different things. I then examined the data more closely in terms of how participants used language and it quickly revealed that not only did participants use language in multiple, ambiguous ways but that these usages were not of equal power. The literature on translation helped to explain how these discourses could co-exist and yet be so disparate.

As the complexity of the analysis grew, it became necessary to develop protocols that made decisions clear and consistent but which also set limits on, and prioritised the material included in the analysis. In particular, the strengths of the emerging themes and the content of the data eventually over-rode many

of the interactive aspects within focus groups. Therefore, for each developing theme I concentrated on making sense of the data as a set of coherent narratives that moved between description and analytic abstraction including a kind of triangulation that aimed to ensure credibility and rigour by continuous movement between participant talk and examples of current themes and issues evident in organisational and national documents and policy statements.

Appendix 9: Glossary of terms, abbreviations and acronyms

AR	Action Research
<i>The Blueprint</i>	The blueprint for mental health services in Aotearoa\New Zealand: The way things need to be (Mental Health Commission, 1998)
CAI	Critical Appreciative Inquiry
CHE	Crown Health Enterprise
DHB	District health Board
H&D	Health and Disability
HFA	Health Funding Authority
Kaupapa Māori	Organisations that operate from an explicitly Māori worldview and cultural approaches
MHAC	Mental health Advocacy Coalition
MHC	Mental Health Commission
MH (CA&T) Act	Mental Health (Compulsory Assessment& Treatment) Act 1992
MoH	Ministry of Health
NGO	Non-government organisation
Peer Support worker	A worker who identifies as having their own experiences of serious psychological distress and who is in a designated support role based on their shared experiences with service users
RHA	Regional Health Authority
WSF	World Schizophrenia Fellowship

References

- Abas, M., Vanderpyl, J., Le Prou, T., Kydd, R., Emery, B., & Foliaki, S. A. (2003). Psychiatric hospitalization: Reasons for admission and alternatives to admission in South Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 37*(5), 620-625.
- Abbott, P., & Wallace, C. (1990). *The sociology of the caring profession*. London, England: Falmer Press
- Ackroyd, S., & Thompson, P. (1999). *Organisational misbehaviour*. London, England: Sage Publications.
- Ackroyd, S. & Wyllie, A. (2002). *Impacts of national media campaign to counter stigma and discrimination associated with mental illness: Survey 4*. Auckland, New Zealand: Phoenix Research.
- Adame, A. L. (2006). *Recovered voices, recovered Lives: A narrative analysis of psychiatric survivors' experiences of recovery* (Doctoral dissertation Miami University). Retrieved from https://etd.ohiolink.edu/rws_etd/document/get/miami1152813614/inlin_e
- Adams, N., Daniels, A., & Compagni, A. (2009). International pathways to mental health transformation. *International Journal of Mental Health, 38*(1), 30-45.
- Agnew, F., Pulotu-Endemann, F. K., Robinson, T. S., Warren, H., Wheeler, A., Erick, M., Hingano, T., & Schmidt-Sopoanga, H. (2004). *Pacific models of mental health service delivery*. Wellington, New Zealand: Health Research Council of New Zealand.
- Ahern L. & Fisher D. (2001). Recovery at your own pace. *Journal of Psychosocial Nursing and Mental Health Services, 39*, 22–33.
- Albrecht, G. (1992). *The disability business*. London, England: Sage Publications.
- Alderson, P. (1998). The importance of theories in health care. *BMJ: British Medical Journal, 317*(7164), 1007.

- Aldhous, P. (2006). Do drug firm links sway psychiatry? *New Scientist*, 190(2549), 14.
- Aldhous, P. (2009). Psychiatrists at war over broadening mental illness definition. *New Scientist*, 204(2738), 38-41.
- Alinsky, S. (1971). *Rules for radicals: A practical primer for realistic radicals*. New York, NY: Vintage.
- Althusser, L. (1971). *Lenin and philosophy and other essays*. London, England: New Left Books.
- Alvesson, M. (2004). Organisational culture and discourse. In D. Grant, C. Hardy, C. Oswick, & L. Putnam (Eds.), *The Sage handbook of organisational discourse* (pp. 317-335). London, England: Sage Publications.
- Alvesson, M., Ashcraft, K. L. & Thomas, R. (2008). Identity matters: Reflections on the construction of identity scholarship in organisation studies. *Organisation*, 15(1), 5-28.
- Alvesson, M., & Deetz, S. (2000). *Critical management research*. London, England: Sage Publications.
- Alvesson, M., & Karreman, D. (2000). Varieties of discourse: On the study of organisations through discourse analysis. *Human Relations*, 53(9), 1125-1149.
- Alvesson, M., & Willmott, H. (1992). *Critical management studies*. London, England: Sage Publications.
- Alvesson, M., & Willmott, H. (2002). Identity regulation as organisational control: Producing the appropriate individual. *The Journal of Management Studies*, 39(5), 619-644.
- American Psychiatric Association, (2013). *The diagnostic and statistical manual of mental disorders DSM-5*. BookpointUS.
- Anspach, R. (1979). From stigma to identity politics: Political activism among the physically disabled and former mental patients. *Social Science & Medicine*, 13, 65-773.

- Anthony W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.
- Anthony, W. A. (2003). Expanding the evidence base in an era of recovery. *Psychiatric Rehabilitation Journal*, 27(1), 1-2.
- Anthony, W. A. (2006). An elephant in the room. *Psychiatric Rehabilitation Journal*, 29(3), 155.
- Anthony, W. A. Rogers, E. S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39(2), 101-114.
- Argyle, N. (2005). *Discussion paper: Weaving the clinician back into the cloth*. MHWD Headlines. Retrieved from: www.mhwd.govt.nz
- Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, 2(1), 1-3.
- Ashcraft, K. L., & Kedrowicz, A. (2002). Self-direction or social support? Non-profit empowerment and the tacit employment contract of organisational communication studies. *Communication Monographs*, 69(1), 88-110.
- Ashcraft, K. L., Kuhn, T., & Cooren, F. (2009). Constitutional amendments: 'Materializing' organisational communication. *The Academy of Management Annals*, 3(1), 1-64.
- Ashcraft, K. L., & Mumby, D. K. (2004). Organising a critical communicology of gender and work. *International Journal of the Sociology of Language*, 2004(166), 19-44.
- Ashcraft, K. L., & Pacanowsky, M. (1996). A woman's worst enemy: Reflections on a narrative of organisational life and female identity. *Journal of Applied Communication Research*, 24(3), 217-239.
- Ashforth, B. E., & Mael, F. (2004). Social identity theory and the organisation. In M. J. Hatch, & M. Schultz (Eds.), *Organisational identity: A reader* (pp. 134-160). Oxford, United Kingdom: Oxford University Press.

- Ashton, T. (1999). The health reforms: To market and back? In J. Boston, P. Dalziel, & John, S. S. (Eds.), *Redesigning the welfare state in New Zealand* (pp. 134–153). Auckland, New Zealand: Oxford University Press
- Ashton, T., Mays, N., & Devlin, N. (2005). Continuity through change: The rhetoric and reality of health reform in New Zealand. *Social Science & Medicine*, *61*(2), 253-262.
- Babrow, A. S., & Kline, K. N. (2000). From "reducing" to "coping with" uncertainty: Reconceptualising the central challenge in breast self-exams. *Social Science & Medicine*, *51*(12), 1805-1816.
- Babrow, A. S., & Mattson, M. (2003). Theorizing about health communication. In T. L. Thompson, A., Dorsey, K. I. Miller, & R. Parrott (Eds.), *The Routledge handbook of health communication* (pp. 35-61). Mahwah, NJ: Lawrence Erlbaum Associates.
- Banks, D., Burdett, J., & Burnett, V. (2004). *Our lives in 2014: A recovery vision from people with experience of mental illness*. Wellington, New Zealand: Mental Health Commission.
- Barber, K. (2005). *It ain't rocket science: Exploring a role for strengths based practice in mental health support work*. (Unpublished master's thesis) University of Auckland, Auckland, New Zealand.
- Barbour, J. B., & Lammers, J. C. (2007). Health care institutions, communication, and physicians' experience of managed care: A multilevel analysis. *Management Communication Quarterly*, *21*(2), 201-231.
- Barge, J. K., & Oliver, C. (2003). Working with appreciation in managerial practice. *Academy of Management Review*, *28*(1), 124-142.
- Barker, P. (2003). The Tidal Model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*, *12*(2), 96-102.
- Barker, P. J. (Ed.). (2011). *Mental health ethics: The human context*. Oxford, England: Routledge.

- Barker, P. J., & Buchanan-Barker, P. (2005). *The tidal model: A guide for mental health professionals*. Hove, England: Routledge.
- Barker, P. J., & Buchanan-Barker, P. (2011). Mental health nursing and the politics of recovery: A global reflection. *Archives of Psychiatric Nursing*, 25(5), 350-358.
- Barker, P. J., & Buchanan-Barker, P. (2012). First do no harm: Confronting the myths of psychiatric drugs. *Nursing Ethics*, 19(4) 451–463.
- Barley, S. R., & Tolbert, P. S. (1997). Institutionalisation and structuration: Studying the links between action and institution. *Organisation Studies*, 18, 93–117.
- Barnett, H., & Barnes, A. (2010). *Walk a mile in our shoes: He tuara, ngā tapuwae tuku iho o ngā mātua tūpuna*. Auckland, New Zealand: Mental Health Foundation of New Zealand.
- Barnett, P., & Newberry, S. (2002). Reshaping community mental health services in a restructured state: New Zealand 1984-97. *Public Management Review*, 4(2), 187-208.
- Barton, R. (1959). *Institutional neurosis*. Bristol, England: John Wright.
- Barton, R. (1972). Institutional neurosis. *British Medical Journal*, 1(5798), 505.
- Baruch, G., & Treacher, A. (1978). Treating the mentally ill. *New Society*, 44(811), 125-127.
- Barwick, H. (1994). *Analysis of the submissions on the Mental Health (Compulsory Assessment & Treatment) Amendment Bill*. Wellington, New Zealand: Ministry of Health.
- Baum, J. A C., & Oliver, C. (1996). Toward an institutional ecology of organisational founding. *Academy of Management Journal*, 39(5), 1378-1427.
- Beck, U. (1992). *Risk society: Towards a new modernity* (Trans. Mark Ritter). London, England: Sage Publications.
- Becker, D. R., Torrey, W. C., Toscano, R., Wyzik, P. F., & Fox, T. S. (1998). Building recovery-oriented services: Lessons from implementing individual

- placement and support (IPS) in community mental health centres. *Psychiatric Rehabilitation Journal*, 22(1), 51.
- Becker, D. R., Xie, H., McHugo, G. J., Halliday, J., & Martinez, R. A. (2006). What predicts supported employment program outcomes? *Community Mental Health Journal*, 42(3), 303.
- Bell, A., & Lindley, P. (2005). *Beyond the water towers: The unfinished revolution in mental health services 1985–2005*. United Kingdom: The Sainsbury Centre for Mental Health.
- Bennett, D. (1991). Community psychiatry. In E. G. Berrios, & H. Freeman (Eds.), *150 years of British psychiatry 1841–1991*. London, England: Gaskell.
- Benson, J. K. (1977). Organisations: A dialectical view. *Administrative Science Quarterly*, 22, 1-21.
- Bentall, R. P., & Pilgrim, D. (1993). Thomas Szasz, crazy talk and the myth of mental illness. *British Journal of Medical Psychology*, 66(1), 69-76.
- Bentham, J., (1791/1995). *Panopticon or the inspection house* (M. Bozovic, ed.). London: Verso
- Berger, P. L., & Luckman, T. (1967). *The social construction of reality*. London, England: Penguin.
- Blundo, R. (2001). Learning strengths-based practice: Challenging our personal and professional frames. *Families in Society*, 82(3), 296-304.
- Boje, D. M. (2001). *Narrative methods for organisational and communication research*. London, England: Sage Publications.
- Boje, D. M. (2010). Side shadowing appreciative inquiry: One storyteller's commentary. *Journal of Management Inquiry*, 19(3) 238–241.
- Boje, D. M., & Dennehy, R. F. (1993). *Managing in the postmodern world: America's revolution against exploitation*. Dubuque, IA: Kendall/Hunt Publishing Company.
- Boje, D. M., & Winsor, R. (1993). The resurrection of Taylorism: Total quality management's hidden agenda. *Journal of Organisational Change Management*, 6 (4), 57-70.

- Bond, C. H. (1915). The position of psychiatry and the role of general hospitals in its improvement. *Journal of Medical Science*, 61, 1-17.
- Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., . . . & Blyler, C. R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services*, 52(3), 313-322.
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British Literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140-153.
- Borch, C. (2005). Systemic power: Lurhmann, Foucault and analytics of power. *Acta Sociologica*, 48(2), 155-167.
- Boston, J., (1996). The use of contracting in the public sector: Recent experience. *Australian Journal of Public Administration*, 55(3), 105-110.
- Boston, J., Dalziel, P., & John, S. S. (Eds.). (1999). *Redesigning the welfare state in New Zealand: Problems, policies, prospects*. Auckland, New Zealand: Oxford University Press.
- Boxenbaum, E. (2005, August). Micro-dynamic mechanisms of translation: A double case study. Best conference paper. In *Academy of Management Proceedings*, 2005(1), D1-D6.
- Boxenbaum, E. (2006). Lost in translation: The making of Danish diversity management. *American Behavioural Scientist*, 49(7), 939-948.
- Boyce, M. E. (1996). Organisational story and storytelling: A critical review. *Journal of Organisational Change Management*, 9(5), 5-26.
- Bracken, P., Khalifa, J., & Thomas, P. (2007). Recent translations of Foucault on mental health. *Current Opinion in Psychiatry*, 20(6), 605-608.
- Bracken, P., & Thomas, P. (1998, July/August). Opening a closed book. *Openmind*, 92, 19.
- Bracken, P., & Thomas P. (1999). Science, psychiatry and the mystery of madness. *Openmind*, 100, 10-11.
- Bracken, P., & Thomas., P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal*, 322(7288), 724-725.

- Bracken, P., & Thomas, P. (2004). Hope. *Openmind*, 130, 10.
- Bracken, P., & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford, England: Oxford University Press.
- Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the role of critical psychiatry. *Philosophy, Psychiatry, & Psychology*, 17(3), 219-228.
- Bradstreet, S., & Connor, A. (2005). Communities of recovery. *Mental Health Today*, May, 22-24.
- Braslow, J. T. (1997). *Mental ills and bodily cures: Psychiatric treatment in the first half of the twentieth century* (Vol. 8). Berkeley, CA: University of California Press
- Breggin, P. (1993). *Toxic psychiatry*. London, England: HarperCollins.
- British Psychological Society, (2000). *Recent Advances in Understanding Mental Illness and Psychotic Experiences*. A Report by the British Psychological Society, Division of Clinical Psychology. Leicester, United Kingdom: British Psychological Society.
- Broadfoot, K. J., & Munshi, D. (2007a). Diverse voices and alternative rationalities: Imagining forms of postcolonial organisational communication. *Management Communication Quarterly*, 21(2), 249-267.
- Broadfoot, K. J., & Munshi, D. (2007b). In search of a polyphony of voices. *Management Communication Quarterly*, 21(2), 281-283
- Brown, A. D. (2000). Making sense of inquiry sense making. *Journal of Management Studies*, 37(1), 45-75.
- Brown, A. D. (2004). Authoritative sense making in a public inquiry report. *Organisation Studies*, 25(1), 95-112.
- Brown, H., & Smith, H. (Eds.). (1992). *Normalisation: A reader for the nineties*. London, England: Routledge.
- Brown, P. (2007). *Toxic exposures: Contested illnesses and the environmental health movement*. New York, NY: Columbia University Press.

- Brown, P., & Funk, S. C. (1986). Tardive dyskinesia: Barriers to the professional recognition of iatrogenic disease. *Journal of Health and Social Behaviour*, 27, 116–132.
- Brown, P., Zavestoski, S., McCormick, S., Mayer, B., Morello-Frosch, R., & Gasior Altman, R. (2004). Embodied health movements: New approaches to social movements in health. *Sociology of Health & Illness*, 26(1), 50-80.
- Brown, S. D. (2002). Michel Serres: Science, translation and the logic of the parasite. *Theory, Culture and Society*, 19(3), 1-27.
- Brunton, M. (2000). *A changing dialogue within health communication in New Zealand: A case study of the Waikato Screening Mammography Programme*. (Doctoral thesis, University of Waikato, Hamilton, New Zealand).
- Brunton, W. (2001). Mental health: The case of deinstitutionalisation. In P. Davis, & T. Ashton, (Eds.), *Health and public policy making* (pp. 181-200). Auckland, New Zealand: Oxford University Press.
- Brunton, W. (2004). Out of the shadows: Some historical underpinnings of mental health policy. In B. Dalley & M. Tennant (Eds.), *Past Judgement: Social policy in New Zealand History* (pp. 75-90). Dunedin, New Zealand: University of Otago Press.
- Brunton, W. (2005). The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996. *Australia and New Zealand Health Policy*, 2(1), 24- 43.
- Buckingham C. (2001). Schizophrenia: The biological and social. *Openmind*, 111, 11.
- Bunkle, P., & Coney, S. (1987, June). An unfortunate experiment at National Women's Hospital. *Metro*, 47-65.
- Burnet, T. (2005). Recovery: A personal journey. Retrieved from <http://www.scottishrecovery.net>

- Cady, S. H., & Caster, M. A. (2000). A diet for action research: An integrated problem and appreciative focussed approach to organisational development. *Organisation Development Journal*, 18(4), 79-93.
- Caird, B. (2001). *Getting a sense of community support work: A review of literature on paradigms to support people who experience mental illness*. Wellington, New Zealand: Ministry of Health.
- Calas, M. B., & Smircich, L. (1999). Past postmodernism? Reflections and tentative directions. *The Academy of Management Review*, 24(4), 649-671.
- Calsamiglia, H. (2003). Popularization discourse. *Discourse studies*, 5(2), 139-146.
- Campbell P. (2001). It's not the real you. *Openmind*, 111, 16–17.
- Campbell-Orde, T., Chamberlin, J., Carpenter, J., & Leff, H. S. (2005). *Measuring the promise: A compendium of recovery measures, Volume 2*. Cambridge, MA: The Evaluation Centre, Human Services Research Institute.
- Canguilhem, G., Cohen, R. S., & Foucault, M. (1989). *The normal and the pathological* (C. R. Fawcett, Trans.). New York, NY: Zone Books.
- Carey, V. (2005). Recovery and wellness: Models of hope and empowerment for people with mental illness. *Psychiatric Rehabilitation Journal*, 28(4), 416.
- Carling, P. (1995). *Return to community: Building support systems for people with psychiatric disabilities*. New York, NY: Guildford Press.
- Carling, P. & Allott, P. (1999). *Beyond mental health services: Integrating resources and supports in the local community*. (Directional paper 2). NHS Executive, West Midlands, United Kingdom.
- Carling P., Allott, P., Smith M., & Coleman R. (1999). *Helping to articulate the direction of the mental health system of the future: Principles of recovery* (Directional paper 3). NHS Executive, West Midlands, United Kingdom.
- Caronna, C. A. (2004). The misalignment of institutional “pillars”: Consequences for the U. S. health care field. *Journal of Health and Social Behaviour*, 45, 45–59.

- Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health & Social Work, 27*(2), 86-94.
- Carpenter, J. , Ring, C. , Sangster, A. , Cambridge, P., & Hatzidimitriadou, E. (2000). From the asylum to the community: A longitudinal study of staff involved in the transition from Tone Vale Hospital to community-based services. *Journal of Mental Health, 9*(2), 211-230.
- Carson, R., (1962). *The silent spring*. Boston, MA: Houghton-Mifflin.
- Carson, R. C. (1997). Costly compromises: A critique of the diagnostic and statistical manual of mental disorders. In S. Fisher, & R. P. Greenberg, (Eds.), *From placebo to panacea: Putting psychiatric drugs to the test* (pp. 98-1140). New York, NY: Wiley.
- Cartwright, S. R., (1988). *The report of the committee of inquiry into allegations concerning the treatment of cervical cancer at National Women's hospital and into other related matters*. Auckland, New Zealand: Government Printing Office.
- Castel, F., Castel, R., & Lovell, A. (1982). *The psychiatric society*. New York, NY: Columbia University Press.
- Central Potential: Te Rito Maia*. (2008). *The services we need: Mental health service users' expectations for the future*. Hawkes Bay, New Zealand: Central Potential.
- Chadwick P. (2002). How to become better after psychosis than you were before. *Openmind, 115*, 12–13.
- Chalmers F. (2001). *Psychiatry 'hijacked' by Big Pharma*. Retrieved from <http://healthmatters.org.uk/issue45/bigpharma>
- Chamberlin J. (1988). *On our own: Patient controlled alternatives to the mental health system*. London, England: MIND.
- Chamberlin, J. (1998). Citizenship rights and psychiatric disability. *Psychiatric Rehabilitation Journal, 21*(4), 405- 408.

- Chamberlin, J. (2004). User-run services. In J. Read, R. Bentall, & L. Mosher (Eds.), *Models of madness: Psychological, social and biological approaches to schizophrenia*, (pp. 283-290). Hove, England: Brunner-Routledge.
- Charmaz, K. (1990). 'Discovering' chronic illness: Using grounded theory. *Social science & medicine*, 30(11), 1161-1172.
- Chavez, K. (2009). Embodied translation: Dominant discourse and communication with migrant bodies-as-text. *Howard Journal of Communications*, 20(1), 18-36.
- Cheney, G. (1983a). The rhetoric of identification and the study of organisational communication. *Quarterly Journal of Speech*, 69(2), 143-158.
- Cheney, G., (1983b). On the various and changing meanings of organisational membership: A field study of organisational identification. *Communication Monographs*, 50(4), 342-362.
- Cheney, G., (1991). *Rhetoric in an organisational society: Managing multiple identities*. Columbia, SC: University of South Carolina Press.
- Cheney, G. (2000). Thinking differently about organisational communication: Why, how, and where? *Management Communication Quarterly*, 14(2), 132-141.
- Cheney, G. (2002). *Values at work: Employee participation meets market pressure at Mondragon*. New York, NY: Cornell University Press.
- Cheney, G., & Ashcraft, K. L., (2007). Considering "the professional" in communication studies. *Communication Theory*, 17(2), 146-175.
- Cheney, G., & Christensen, L. T. (2001). Organisational identity: Linkages between internal and external communication. In F. M. Jablin & L. Putnam (Eds.), *The new handbook of organisational communication: Advances in theory, research, and methods* (pp. 231-269). Thousand Oaks, CA: Sage Publications.
- Cheney, G., Christensen, L. T., Zorn, T., & Ganesh, S. (2004). *Organisational communication in an age of globalisation*. Long Grove, Illinois: Waveland Press.

- Cheney, G., & Cloud, D. L. (2006). Doing democracy, engaging the material: Employee participation and labour activity in an age of market globalization. *Management Communication Quarterly*, 19(4), 501-540.
- Chetkovich, C., & Frumkin, P. (2003). Balancing margin and mission: Non-profit competition in charitable versus fee-based programs. *Administration & Society*, 35(5), 564-596.
- Cheyne, C., O'Brien, M., & Belgrave, M. (2000). *Social policy in Aotearoa/New Zealand: A critical introduction*. Auckland, New Zealand: Oxford University Press.
- Christensen, L. T., & Cheney, G. (1994). Articulating identity in an organisational age. *Communication yearbook*, 17, 222-235.
- Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry* (pp. 35-75). Thousand Oaks, CA: Sage Publications.
- Clare, A. W. (1980). *Psychiatry in dissent: Controversial issues in thought and practice* (2nd ed.). London, England: Tavistock Publications.
- Clark, C., & Krupa, T. (2002). Reflections on empowerment in community mental health: Giving shape to an elusive idea. *Psychiatric Rehabilitation Journal*, 25(4), 341-349.
- Clemente, M., & Roulet, T. (2015). Public opinion as a source of deinstitutionalisation: A 'spiral of silence' approach. *Academy of Management Review*, 40(1), 196-114.
- Clifford, J. (1988). *The predicament of culture*. Cambridge, MA: Harvard University Press.
- Cohen, D. (1997). A critique of the use of neuroleptic drugs in psychiatry. In S. Fisher & R. P. Greenburg (Eds.), *From placebo to panacea: Putting psychiatric drugs to the test*. New York, NY: Wiley.
- Cohen, J. (1985). Strategy or identity: New theoretical paradigms and contemporary social movements. *Social Research*, 52, 663-716.

- Coleborne, C. (2012). Patient journeys: Stories of mental health care from Tokaanui to mental health services: 1930s to the 1980s. In C. Coleborne, & The Waikato Mental History Group (Eds.), *Changing times, changing places* (pp. 97-109). Hamilton: New Zealand.
- Coleborne, C., & Mackinnon, D. (2006). Psychiatry and its institutions in Australia and New Zealand: An overview. *International Review of Psychiatry*, 18(4), 371–380.
- Coleman R. (1999). *Recovery: An alien concept*. Gloucester, United Kingdom: Handsell Publishing.
- Coleman, R., Goodman, J., & Smith, M. (Eds.). (2003). *First aid in psychosis*. Wellington, New Zealand: Keepwell Publications.
- Colomy, P. (1998). Neofunctionalism and neoinstitutionalism: Human agency and interest in institutional change. *Sociological Forum*, 13(2), 265-300.
- Comte, A. (1856/1957). *A general view of positivism* (J. H. Bridges, Trans.). New York: R. Speller & Sons
- Coney S. (1988). *The unfortunate experiment*. Auckland, New Zealand: Penguin Books.
- Coney, S. (2004). *Effective consumer voice and participation for New Zealand*. Wellington, New Zealand: New Zealand Guidelines Group.
- Conger, J. A., & Kanungo, R. N. (1987). Toward a behavioural theory of charismatic leadership in organisational settings. *Academy of Management Review*, 12(4), 637-647.
- Conle, C. (2001). The rationality of narrative inquiry in research and professional development. *European Journal of Teacher Education*, 24(1), 21-33.
- Conrad, C., & McIntush, H. G. (2003). Organisational rhetoric and healthcare policymaking. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of health communication* (2nd ed., pp. 403-422). New York, NY: Routledge.

- Conrad, C., & Jodlowski, D. (2008). Dealing drugs on the border. In H. Zoller & M. Dutta (Eds.) *Emerging perspectives in health* (pp. 365-389). Mahwah, NJ: Lawrence Erlbaum Associates.
- Conrad, P., & Schneider, J. (1990). *Deviance and medicalisation: From badness to sickness* (2nd ed.). Philadelphia, PA: Temple University Press.
- Cook, J. A., & Wright, E. R. (1995). Medical sociology and the study of severe mental illness: Reflections on past accomplishments and directions for future research. *Journal of Health and Social Behaviour*, 35, 95-114.
- Cooks, L. (2000). Toward a practical theory for training in social justice: Participation, identity and power among women's groups in Panama. *World Communication*, 29(2), 3.
- Cooper, R. (2004). What is wrong with DSM? *History of Psychiatry*, 15(1), 1-25.
- Cooper, S., Darmody, M., & Dolan, Y. (2003). Impressions of hope and its influence in the process of change: An international e-mail dialogue. *Journal of Systemic Therapies*, 22(3), 67-78.
- Cooperrider, D. L., & Srivastva, S. (1987). Appreciative inquiry in organisational life. *Research in organisational change and development*, 1(1), 129-169
- Cooperrider, D., & Whitney, D. D. (2005). *Appreciative inquiry: A positive revolution in change*. San Francisco, CA: Berrett-Koehler Publishers.
- Cooren, F. (2001). Translation and articulation in the organisation of coalitions: the Great Whale River case. *Communication Theory*, 11(2), 178-200.
- Copeland, M. E. (1997). *Wellness recovery action plan*. Brattleboro, VT: Peach Press.
- Craddock, N., Antebi, D., Attenburrow, M. J., Bailey, A., Carson, A., Cowen, P., & Zammit, S. (2008). Wake-up call for British psychiatry. *The British Journal of Psychiatry*, 193(1), 6-9.
- Creed, W. E. D., Scully, M. A. S., & Austin, J. R. (2002). Clothes make the person? The tailoring of legitimating accounts and the social construction of identity. *Organisation Science*, 13(5), 475-496.

- Cresswell, M. (2009). Psychiatric survivors and experiential rights. *Social Policy and Society*, 8(2), 231-243.
- Cronin, M. (2005). Burning the house down: Translation in a global setting. *Language and Intercultural Communication*, 5(2), 108-119.
- Cunliffe, A., & Coupland, C. (2012). From hero to villain to hero: Making experience sensible through embodied narrative sensemaking. *Human Relations*, 65(1), 63-88.
- Curtis L. (1997). *New directions: International overview of best practices in recovery and rehabilitation for people with serious mental illness*. Burlington, VT: Trinity College.
- Curtis L., & Hodge M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. In Publications Committee of IAPSRs (Ed.), *An introduction to psychiatric rehabilitation* (pp. 339-356). Boston, MA: International Association of Psychosocial Rehabilitation Services.
- Cutcliffe, J. R., & Hannigan, H. (2001). Mass media, 'monsters' and mental health clients: The need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing*, 8(4), 315-321.
- Czarniawska-Joerges, B. (1994). Narratives of individual and organisational identities. *Communication Yearbook*, 17, 193-221
- Czarniawska-Joerges, B., & Joerges, B. (1988). How to control things with words: Organisational talk and control. *Management Communication Quarterly*, 2(2), 170-193.
- Czarniawska-Joerges, B., & Joerges, B. (1995). Winds of organisational change: How ideas translate into objects and actions. In N. Brunsson, & J. P. Olsen (Eds.), *Organising organisations* (pp. 197-236). Oslo, Norway: Fagbokforlaget.
- Czarniawska-Joerges, B., & Wolff, R. (1998). Constructing new identities in established organisational fields. *International Studies of Management & Organisation*, 28(3), 32-56.

- Dacin, M. T., Oliver, C., & Jean-Paul, R. (2007). The legitimacy of strategic alliances: An institutional perspective. *Strategic Management Journal*, 28(2), 169-187.
- Dalley, B., & Tennant, M. (2004). *Past judgement: Social policy in New Zealand history*. Dunedin, New Zealand: University of Otago Press.
- Dalley, G. (1988). *Ideologies of caring: Rethinking community and collectivism*. Basingstoke, England: Macmillan Education.
- Dalley, G. (Ed). (1991). Disability and social policy. In G. Dalley (Ed.), *Disability and social policy* (pp. 1-18). London, England: Policy Studies Institute.
- Dalley, G. (1992). Social welfare ideologies and normalisation: Links and conflicts. In H. Brown, & H. Smith (Eds.), *Normalisation: A reader for the nineties* (pp. 100-111). London, England: Routledge.
- Daniels, N., Kennedy, B. P., & Kawachi, I. (1999). Why justice is good for our health: The social determinants of health inequalities. *Daedalus*, 128(4), 215-251.
- Davenport, S., & Leitch, S. (2005). Circuits of power in practice: Strategic ambiguity as delegation of authority. *Organisation Studies*, 26(11), 1603–1623.
- Davidson, C., & Tolich, M. (1999). *Social science research in New Zealand: Many paths to understanding*. Auckland, New Zealand: Longman.
- Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640–645.
- Davidson, L., Tondora, J., O'Connell, M. J., Kirk, T. Jr., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioural health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31(1), 23–31.
- Davis, P., & Ashton, T. (Eds.). (2001). *Health and public policy in New Zealand*. Auckland, New Zealand: Oxford University Press

- De Cock, C. (1998). Organisational change and discourse: Hegemony, resistance and reconstitution. *M@n@gement*, 1(1), 1-22.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 4(11), 11-19.
- Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 3(19), 91-97.
- Deetz, S. (1992a). Disciplinary power in the modern corporation. In M. Alvesson & H. Willmott (Eds.), *Critical management studies* (pp. 21–45). London, England: Sage Publications.
- Deetz, S. (1992b). *Democracy in an age of corporate colonisation*. New York, NY: State University of New York Press.
- Deetz, S. (2003). Disciplinary power, conflict suppression and human resources management. In M Alvesson & H. Willmott (Eds.), *Studying management critically*. London, England: Sage Publications.
- Deetz, S. (2005). Critical theory. In S. K. May & D. K. Mumby (Eds.), *Engaging organisational communication theory and research*. London, England: Sage Publications.
- Deetz, S., & Kersten, A. (1983). Critical models of interpretive research. In L. Putnam & M. Pacanowsky (Eds.), *Communication and organisations: An interpretive approach* (pp. 147-171). Beverly Hills CA: Sage Publications.
- Deetz, S., & Mumby, D. K. (1990). Power, discourse, and the workplace: Reclaiming the critical tradition. *Communication Yearbook* 13(1), 18-47.
- Dellar, R., Lesley, E., Watson, B., & Curtis, T. (2000). *Mad Pride: A celebration of mad culture*. London, England: Chipmunka Publishing
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (1998). *The landscape of qualitative research*. Thousand Oaks, CA: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *Strategies of qualitative inquiry* (Vol. 2). Thousand Oaks, CA: Sage Publications.

- Department of Health. (1999). *A national service framework for mental health: Modern standards and service models*. London, England: Stationery Office.
- Depoe, S. P., Delicath, J. W., & Elsenbeer, M. F. A. (Eds.). (2004). *Communication and public participation in environmental decision making*. New York, NY: SUNY Press.
- Dey, P., Teasdale, S. (2013). Social enterprise and dis/identification: The politics of identity work in the English third sector. *Administrative Theory & Praxis*, 35(2), 248-270.
- Dick, R., (2009). Action research literature 2006--2008: Themes and trends. *Action Research*, 7(4), 423-441.
- DiMaggio, P. J., & Powell, W. W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organisational fields. *American Sociological Review*, 48(2), 147-160.
- DiMaggio, P. J., & Powell, W. W. (1991). Introduction. In: W. W. Powell & P. J. DiMaggio (Eds.), *The New Institutionalism in Organisational Analysis* (pp. 1–38). Chicago, IL: University of Chicago Press
- Doolin, B. (2007). Biotechnology discourse. *Discourse Studies*, 9(5), 5-8.
- Double, D. (2002). The limits of psychiatry. *British Medical Journal* (International ed.), 324(7342), 900-904.
- Double, D. (Ed.). (2006). *Critical psychiatry: The limits of madness*. London, England: Palgrave Macmillan.
- Douglas, M. (1986). *How institutions think*. Syracuse, NY: Syracuse University Press.
- Drake, R. E., Green, A. I., Mueser, K. T., & Goldman, H. H. (2003). The history of community mental health treatment and rehabilitation for persons with severe mental illness. *Community Mental Health Journal*, 39(5), 427-440.
- Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). *The heroic client*. San Francisco, CA: Jossey-Bass.

- Durie, M H. (1985). A Māori perspective of health. *Social Science and Medicine*, 20(5), 483-486.
- Durie, M. H. (1994). *Whānau, family and the promotion of health*. Palmerston North, New Zealand: Massey University, Department of Māori Studies.
- Durie, M. (1998). *Whaiora: Māori health development* (2nd ed.). Auckland, New Zealand: Oxford University Press.
- Durie, M. (1999). Mental health and Māori development. *Australian and New Zealand Journal of Psychiatry*, 33(1), 5-12.
- Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Auckland, New Zealand: Oxford University Press.
- Durie, M. (2009). Māori knowledge and medical science. In M. Incayawar, R. Wintrob & L. Bouchard (Eds.), *Psychiatrists and traditional healers: Unwitting partners in global mental health* (pp. 237-249). Sussex, United Kingdom: Wiley-Blackwell.
- Durrant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design*. New York, NY: W. W. Norton.
- Dutta, M. J. (2015). *Neoliberal Health Organizing: Communication, Meaning, and Politics*. Walnut Creek, CA: Left Coast Print Inc.
- Dutta, M. J., & Zoller, H. M. (2008). Theoretical foundations: Interpretive, critical, and cultural approaches to health communication: Meaning, culture and power. In M. J. Dutta & H. M. Zoller (Eds.), *Emerging perspectives in health communication* (pp. 1-27). New York, NY: Routledge.
- Dyall, L. (1997). *Hauora o te Hinengaro: Pathway to Māori mental health and wellness*. Paper presented to *Rangahau Hauora Hinengaro: Māori Mental Health Summit*. Manawanui Marae, Auckland, New Zealand.
- Edgley, A., Stickley, T., & Masterson, S. (2006). Whose right? *Journal of Mental Health*, 15(1), 35-42.
- Edson, M. (1999). *Wit*. New York, NY: Faber and Faber.
- Ehrenreich, B. (2009). *Bright-sided*. New York, NY: Metropolitan Books.

- Eisenberg, E. (1984). Ambiguity as strategy in organisational communication. *Communication Monographs*, 51(3), 227-242.
- Eisenberg, E. M., Murphy, A. G., Sutcliffe, K., Wears, R., Schenkel, S., Perry, S., & Vanderhoef, M. (2005). Communication in emergency medicine: Implications for patient safety. *Communication Monographs*, 72(4), 390-413.
- Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, 14(4), 532-550.
- Emerson, R. M. (1981). On last resorts. *American Journal of Sociology*, 87, 1-22.
- Everett, B. (1994). Something is happening: The contemporary consumer and psychiatric survivor movement in historical context. *The Journal of Mind and Behaviour*, 15(2), 55-70.
- Fairclough, N. (1992). *Discourse and social change*. Cambridge, United Kingdom: Polity Press.
- Fairclough, N. (1993). Critical discourse analysis and the marketization of public discourse: The universities. *Discourse & Society*, 4(2), 133-168.
- Fairhurst, G. T., & Putnam, L. (2004). Organisations as discursive constructions. *Communication Theory*, 14(1), 5-26.
- Fakhoury, W., & Priebe, S. (2002). The process of deinstitutionalisation: An international overview. *Current Opinion in Psychiatry*, 15(2), 187-192.
- Fakhoury, W., & Priebe, S., (2007). Deinstitutionalisation and reinstitutionalisation: Major changes in the provision of mental healthcare. *Psychiatry*, 6(8), 313-316.
- Farjoun, M. (2002). The dialectics of institutional development in emerging and turbulent fields: The history of pricing conventions in the on-line database industry. *Academy of Management Journal*, 45(5), 848-874.
- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41(2), 141-158.

- Fee, D. (Ed.). (1999). *Pathology and the postmodern: Mental illness as discourse and experience*. London, England: Sage Publications.
- Fenton, L., & Te Koutua, T. W. (2000). *Four Māori korero about their experience of mental illness*. Wellington, New Zealand: Mental Health Commission.
- Fern, E. (1982). Why do focus groups work: A review and integration of small group process theories. *Advances in Consumer Research*, 9(1), 444-451.
- Fineman, S. (2006a). On being positive: Concerns and counterpoints. *Academy of Management Review*, 31(2), 270-291.
- Fineman, S. (2006b). Accentuating the Positive?. *Academy of Management Review*, 31(2), 306-308.
- Finn, S. E., Bailey, J. M., Schultz, R. T., & Faber, R. (1990). Subjective utility ratings of neuroleptics in treating schizophrenia. *Psychological Medicine*, 20(4), 843-8.
- Fisher, D. (1994a). Health care reform based on an empowerment model of recovery by people with psychiatric disabilities. *Hospital and Community Psychiatry*, 45(9), 913-915.
- Fisher, D. (1994b). A new vision of healing as constructed by people with psychiatric disabilities working as mental health providers. *Psychosocial Rehabilitation Journal*, 17(3), 67-81.
- Fisher D. (2000). Hope, humanity and voice in recovery from mental illness In P. Barker, P. Campbell, & B. Davidson (Eds.), *From the ashes of experience: Reflections on madness, survival and growth* (pp. 127–133). London, England: Whurr Publishers.
- Fisher, S., & Greenberg, R. P. (Eds.) (1997). *From placebo to panacea: Putting psychiatric drugs to the test*. New York, NY: Wiley.
- Fitzgerald, S. P., Oliver, C., & Hoxsey, J. C., (2010). Appreciative inquiry as a shadow process. *Journal of Management Inquiry*, 19(3), 220-233.
- Fitzsimons, S., & Fuller, R. (2002). Empowerment and its implications for clinical practice in mental health: A review. *Journal of Mental Health*, 11(5), 481-499.

- Flanagin, A. J., Stohl, C., & Bimber, B. (2006). Modelling the structure of collective action. *Communication Monographs*, 73(1), 29-54.
- Forman, M. (Director). (1975). *One flew over the cuckoo's nest* [Motion Picture]. United States of America: United Artists.
- Foucault, M. (1963). *The birth of the clinic* (A. Sheridan, Trans.). London, England: Tavistock.
- Foucault, M. (1970). *The order of things: An archaeology of the human sciences*. New York, NY: Vintage.
- Foucault, M. (1972). *The archaeology of knowledge and the discourse on language* (A. Sheridan, Trans.). New York, NY: Pantheon.
- Foucault, M. (1973). *Madness and civilisation: A history of insanity in the age of reason*. New York, NY: Random House.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*, (A. Sheridan Trans.). New York, NY: Vintage.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings*. New York, NY: Pantheon.
- Fougere, G. (2001). Transforming health sectors: New logics of organising in the New Zealand health system. *Social Science and Medicine*, 52(8), 1233-1242.
- Frame, J. (1960). *Owls do cry: A novel*. New York, NY: G. Braziller.
- Frame, J., & Bartlett, C. (1982). *To the is-land: An autobiography (Vol. 1)*. New York, NY: G. Braziller.
- Frame, J. (1984). *An angel at my table: An autobiography (Vol. 2)*. London, England: Women's Press.
- Frame, J. (1985). *The envoy from mirror city: An autobiography (Vol. 3)*. London, England: Women's Press.
- Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalisation of ordinary life*. New York, NY: William Morrow.

- Freire, P. (1970). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). New York, NY: Continuum.
- Frese, F. J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services, 52*(11), 1462-1468.
- Frumkin, P., & Galaskiewicz, J., A. (2004). Institutional isomorphism and public sector organisations. *Journal of Public Administration and Theory, 14*(3), 283-307.
- Frumkin, P., & Andre-Clark, A., (2000). When missions, markets, and politics collide: Values and strategy in the non-profit human services. *Non-profit and Voluntary Sector Quarterly, 29*(1), 141-163.
- Fuller, C., Griffin, T., & Ludema, J. (2000). Appreciative future search: Involving the whole system in positive organisation change. *Organisational Development Journal, 18*(2), 29-41.
- Ganesh, S. (2003). Organisational narcissism. *Management Communication Quarterly, 16*(4) 558-594.
- Ganesh, S. (2005). The myth of the non-governmental organisation: Governmentality and transnationalism in an Indian NGO. *International and Multicultural Organisational Communication, 7*, 193-219.
- Ganesh, S. (2008). Organisational communication: Postmodern approaches. In W. Donsbach (Ed.), *The international encyclopaedia of communication* (pp. 3433-3438). Washington, DC: International Communication Association.
- Ganesh, S. (2010). Translating critical management studies. Paper presented at the Organisation, Identity, Location (OIL) 6th Symposium *Critical Theory*. Victoria University, Wellington, New Zealand.
- Ganesh, S., & Barber, K. (2009). The silent community: Organising zones in the digital divide. *Human Relations, 62*(6), 851- 874.

- Ganesh, S., & McAllum, K. (2010). Well-being as discourse: Potentials and problems for studies of organising and health inequalities. *Management Communication Quarterly*, 24(3), 491– 498.
- Ganesh, S., & Stohl, C. (2013). Community organising, social movements and collective action. In L. Putnam & D. Mumby (Eds.), *The SAGE handbook of organisational communication: Advances in theory, research, and methods* (3rd ed., pp. 743-765). Thousand Oaks, CA: Sage Publications.
- Ganesh, S., & Zoller, H. (2012). Dialogue, activism, and democratic social change. *Communication Theory*, 22(1), 66-91.
- Ganesh, S., Zoller, H., & Cheney, G. (2005). Organisational Communication Meets Globalisation from Below. *Communication Monographs*, 72(2), 169–191.
- Garfield, S. I. (1994). Research on client variables in psychotherapy. In S. I. Garfield, & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (pp. 190-228). New York, NY: John Wiley and Sons.
- Gawith, L., & Abrams, P. (2006). Long journey to recovery for Kiwi consumers: Recent developments in mental health policy and practice in New Zealand. *Australian Psychologist*, 41(2), 140-148.
- Geist, P., & Dreyer, J. (1993). The demise of dialogue: A critique of medical encounter ideology. *Western Journal of Communication*, 57(2), 233-246.
- Gerbner, G. (1980). Dreams that hurt: Mental illness in the mass media. In R. C. Baron, I. D. Rutman, & G. Klaczynska (Eds.), *The community imperative* (pp. 19-23). Philadelphia, PA: Horizon House Institute.
- Gergen, K. J., & Thatchenkery, T. J. (1996). Organisation science as social construction: Postmodern potentials. *The Journal of Applied Behavioural Science*, 32(4), 356-377.
- Gergen, K. J. (2001). *Social construction in context*. London, England: Sage Publications.

- Gill, R. (2011). *A superhero on Utah's silicon slopes?: The construction and practice of entrepreneurial identities at the nexus of religion, gender, and place*. (Doctoral dissertation). The University of Utah, Salt Lake City, Utah
- Gillespie, S R. (2001). The politics of breathing: Asthmatic Medicaid patients under managed care. *Journal of Applied Communication Research*, 29(2), 97-116.
- Golant, B. D., & Sillince, J. A. (2007). The constitution of organisational legitimacy: A narrative perspective. *Organisation Studies*, 28(08), 1149–1167.
- Goldberg, D. P., & Huxley, P. (1992). *Common mental disorders: A bio-social model*. Tavistock, United Kingdom: Routledge.
- Goldsack, S., Reet, M., Lapsley, H., & Gingel, M. (2005). *Experiencing a recovery-oriented acute mental health service: Home based treatment from the perspectives of service users, their families and mental health professionals*. Wellington, New Zealand: Mental Health Commission.
- Goslyn, A. (1997). *Psychiatric drugs and side-effects*. Auckland, New Zealand: ANOPS.
- Goslyn, A. (Ed.). (1998). *Mental health. A review of 1997*. Wellington, New Zealand: Mental Health Foundation.
- Goss, T., Pascale, R., & Athos, A. (1993). The reinvention roller coaster: Risking the present for a powerful future. *Harvard Business Review*, 71(6), 97-108.
- Gould, A., DeSouza, S., & Rebeiro-Gruhl, K. (2005). And then I lost that life: A shared narrative of four young men with schizophrenia. *British Journal of Occupational Therapy*, 68(10), 467–473.
- Gramsci, A. (1971). *Selections from the prison notebooks of Antonio Gramsci*. New York, NY: International Publishers.
- Grant, S., & Humphries, M. (2006). Critical evaluation of appreciative inquiry: Bridging an apparent paradox. *Action Research*, 4(4), 401–418.
- Greenberg, M. (1968). *The terror of art: Kafka and modern literature*. New York, NY: Basic Books.

- Greenhalgh, T. (1999). Narrative based medicine in an evidence based world. *BMJ*, 318(7179), 323-325.
- Greenhalgh T., Robert G., Macfarlane F., Bate P., Kyriakidou O., Peacock R. (2005). Storylines of research in diffusion of innovation: A meta-narrative approach to systematic review. *Social Sciences and Medicine*. 61(2), 417–430.
- Grob, G. N. (1991). *From asylum to community: Mental health policy in modern America*. Princeton, NJ: Princeton University Press.
- Grob, G. (1994). *The mad among us: A history of the care of America's mentally ill*. New York, NY: Free Press.
- Grob, G. N. (1995). The paradox of deinstitutionalization. *Society*, 32(5), 51-59.
- Grob, G. N. (2004). The ambivalent character of American psychiatry. *Journal of Health Politics, Policy and Law* 29(3), 515-525.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In Denzin, N. K. & Lincoln, Y. S. (Eds.), *Handbook of Qualitative Research* (pp. 163-194). Thousand Oaks, CA: Sage Publications.
- Guze, S. B. (1989). Biological psychiatry: Is there any other kind? *Psychological Medicine*, 19(2), 315-323.
- Gwyn, R. (2002). *Communicating health and illness*. Thousand Oaks, CA: Sage Publications.
- Habermas, J. (1987). *Theory of communicative action (Vol. 2): System and lifeworld: The critique of functionalist reason* (T. McCarthy, Trans.). Boston, MA: Beacon.
- Hall, J., & Hammond, S. (1998a). What is appreciative inquiry? In S. Hammond & C. Royal (Eds.), *Lessons from the field: Applying appreciative inquiry*. Plano, TX: Thin Book Publishing.
- Hamilton, C., Adolphs, S., & Nerlich, B. (2007). The meanings of 'risk': A view from corpus linguistics. *Discourse & Society*, 18(2), 163-181.
- Hammond, S., & Royal, C. (1998b). *Lessons from the field: Applying appreciative inquiry*. Plano, TX: Practical Press.

- Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., & Wiersma, D. (2001). Recovery from psychotic illness: A 15-and 25-year international follow-up study. *The British Journal of Psychiatry*, 178(6), 506-517.
- Harrison, H. (2010). *The NGO sector role: A key contributor to New Zealand's health and disability services*. Wellington, New Zealand: NGO Health and Disability Working Group.
- Harter, L. M. (2009). Narratives as dialogic, contested, and aesthetic performances. *Journal of Applied Communication Research*, 37(2), 140-150.
- Harter, L. M., Japp, P. M., & Beck, C. S. (2005). Vital problematics of narrative theorising about health and healing. In L. M. Harter, P. M. Japp, & C. S. Beck (Eds.), *Narratives, health, and healing: Communication theory, research, and practice* (pp. 7-29). Mahwah, NJ: Lawrence Erlbaum Associates
- Harter, L. M., Patterson, S., & Gerbensky-Kerber, A. (2010). Narrating "new normals" in health care contexts. *Management Communication Quarterly*, 24(3), 465-473.
- Harter, L. M., Scott, J., Novak, D., Leeman, M., & Morris, J. (2006). Freedom through flight: Performing a counter-narrative of disability. *Journal of Applied Communication Research*, 34(1), 3-29.
- Hazelton M. (1997). Reporting mental health: A discourse analysis of mental health-related news in two Australian newspapers. *Australia & New Zealand Journal of Mental Health Nursing*, 6(2), 73-89.
- Health and Disability Commissioner Act, New Zealand Statute, No.88. (1994)
- Health and Disability Commission. (1999). *Code of health and disability services consumers' rights*. Wellington, New Zealand: Health and Disability Commission, b12.
- Health and Disability Non-Government Organisation Working Group, (2010). *NGO sector strengths and new directions: Opportunities for working together*. Wellington, New Zealand: Ministry of Health.

- Healy, D. (2002). *The creation of psychopharmacology*. Cambridge, MA: Harvard University Press.
- Henderson, A., Weaver, C. K., & Cheney, G. (2007). Talking 'facts': Identity and rationality in industry perspectives on genetic modification. *Discourse Studies*, 9(1), 9-41.
- Hill, R., & Capper, P. (1999). Action Research. In C. Davidson & M. Tolich (Eds.), *Social Science Research in New Zealand: Many paths to understanding* (pp. 243-254). Auckland, New Zealand: Pearson Education in New Zealand.
- Hinings, C. R., & Greenwood, R. (1988). *The dynamics of strategic change*. Oxford, United Kingdom: Basil Blackwell.
- Hobbs, C., Tennant, C., Rosen, A., Newton, L., Lapsley, H. M., Tribe, K., & Brown, J. E. (2000). Deinstitutionalisation for long-term mental illness: A 2-year clinical evaluation. *Australian and New Zealand Journal of Psychiatry*, 34(3), 476-483.
- Hoffman, A. J. (1999). Institutional evolution and change: Environmentalism and the U. S. chemical industry. *Academy of Management Journal*, 42(4), 351-371.
- Hoffman, A. J., Riley, H. C., Troast, J. G., & Bazerman, M. H. (2002). Cognitive and institutional barriers to new forms of cooperation on environmental protection: Insights from Project XL and Habitat Conservation Plans. *American Behavioural Scientist*, 45(5), 820-845.
- Hollingshead, A. B., & Redlich, F. C. (1958). *Social class and mental illness*. New York, NY: Wiley.
- Holloway, F. (2008). Is there a science of recovery and does it matter? *Advances in Psychiatric Treatment*, 14(4), 245-247.
- Holmer-Nadesan, M. (1996). Organisational identity and space of action. *Organisation Studies*, 17(1) 49-81.
- Honneth, A. (2002). Recognition or redistribution. Changing perspectives on the moral order of society. In S. Lash and M. Featherstone (Eds.), *Recognition*

- and difference: Politics, identity, multicultural* (pp. 43-55). London, England: Sage Publications.
- Huberman, A M., & Miles, M. B, (1994). Data management and analysis methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 428-444). Thousand Oaks, CA: Sage Publications.
- Hubble, M., Duncan, B., & Miller, S. D. (1999). *The heart and soul of change*. Washington DC: American Psychological Association.
- Hwang, H., & Powell, W. (2009). The rationalisation of charity: The influences of professionalism in the non-profit sector. *Administrative Science Quarterly*, 54(2), 268–298.
- Jackall, R. (1988). *Moral mazes: The world of corporate managers*. New York, NY: Oxford.
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24(3), 248-256.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the States. *Psychiatric Rehabilitation Journal*, 23(4), 333-341.
- Jacobson, N., & Greenley, D. (2001). What is recovery? A Conceptual model and explication. *Psychiatric Services*, 52(4), 482-487.
- Jackall, R. (1988). *Moral mazes*. New York, NY: Oxford University Press.
- James, A. (2006). Is critical psychiatry a threat? *Openmind*, 142, November/December.
- Jarzabkowski, P., Sillince, J., & Shaw, D. (2009). Strategic ambiguity as a rhetorical resource for enabling multiple interests. *Human Relations*, 63(2), 219-248.
- Jepperson, R. L. (1991). Institutions, institutional effects, and institutionalism. In W. W. Powell & P. J. DiMaggio (Eds.), *The new institutionalism in organisational analysis* (pp. 143–163). Chicago, IL: University of Chicago Press.

- Jermier, J. (1998). Introduction: Critical perspectives on organisational control. *Administrative Services Quarterly*, 43(2), 235-257.
- Johns, C. (2010). *A place of our own: Living with the legacy of institutionalisation*. Wellington, New Zealand: People First.
- Joseph, A. E., & Kearns, R. A. (1996). Deinstitutionalisation meets restructuring: The closure of a psychiatric hospital in New Zealand. *Health & Place*, 2(3), 179-189.
- Joseph, A. E., & Kearns, R. A., (1999). Unhealthy acts: Narratives of community mental health care in Waikato, New Zealand. *Health and Social Care in the Community*, 7(1), 1-8.
- 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.
- Jureidini, J. (2012). Explanations and unexplanations: Restoring meaning to psychiatry. *Australia and New Zealand Journal of Psychiatry*, 46(3), 188-191.
- Kamens, S. R. (2011). On the proposed sexual and gender identity diagnoses for DSM-5: History and controversies. *The Humanistic Psychologist*, 39(1), 37-59.
- Kanter, R. M., & Summers, D. V. (1994). Doing well while doing good: Dilemmas of performance measurement in non-profit organisations and the need for a multiple-constituency approach. In W. W. Powell (Ed.), *The Non-Profit Sector* (pp. 220-246). New Haven, CT: Yale University Press.
- Kearns, R. A., J, R. B., & Newman, D. (2003). Placing private health care: Reading Ascot hospital in the landscape of contemporary Auckland. *Social Science & Medicine*, 56(11), 2303-2316.
- Kecmanovic, D., & Hadzi-Pavlovic, D. (2010). Psychiatric journals as the mirror of the dominant psychiatric model. *The Psychiatrist*, 34(5), 172-176.
- Kendell, R. E. (2000). The next 25 years. *British Journal of Psychiatry*, 176(1), 6-9.

- Kendell, R. E., & Zabransky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry*, *160*(1), 4-12.
- Kendell, R. E., & Zealley, A. K. (1988). *Companion to psychiatric studies* (4th Ed.). Edinburgh: Churchill Livingstone.
- Kendrick, M. (1997). The leadership challenge of service quality. *Interaction (Canberra)*, *11*(1), 12-20.
- Kendrick, M. (2012). As the years pass: Reflections on the last 25 years and looking forward. *Interaction*, *25*(3), 6- 15.
- Kendrick, M. J., Petty, R. E., Bezanson, L., & Jones, D. L. (2006). *Promoting self-direction and consumer control in home-and community-based service systems*. Houston, TX: The Institute for Rehabilitation and Research.
- Kennedy C. H., Horner R. H. & Newton J. S. (1989). Social contacts of adults with severe disabilities living in the community: A descriptive analysis of relationship patterns. *Journal of the Association for Persons with Severe Handicaps*, *14*(3), 190–196.
- Kent, H., & Read, J. (John) (1998). Measuring consumer participation in mental health services: Are attitudes related to professional orientation? *International Journal of Social Psychiatry*, *44*(4), 295-310.
- Kesey, K. (1962). *One flew over the cuckoo's nest*. New York, NY: The Viking Press.
- Keys, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. *Journal of Health & Social Behaviour*, *43*(2), 207-222.
- Keys, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *The American Psychologist*, *62*(2), 95-108.
- Kidd, P. S., & Parshall, M. B. (2000). Getting the focus and the group: Enhancing analytical rigor in focus group research. *Qualitative Health Research*, *10*(3), 293-308.

- Kincheloe, J., & McLaren, P., (1998). Rethinking critical theory and qualitative research. In Y. Lincoln, & N. Denzin, (Eds.). *The landscape of qualitative research: Theories and issues* (pp. 260-299). Thousand Oaks, CA: Sage Publications.
- Kinsella, W. J. (2004). Public expertise: A foundation for citizen participation in energy and environmental decisions. In S. P. Depoe, J. W. Delicath, & M. A. Elsenbeer (Eds.), *Communication and public participation in environmental decision making* (pp. 83-95). Albany, NY: SUNY Press.
- Kirk, S., & Kutchins, H. (1992). *The Selling of DSM: The rhetoric of science in psychiatry*. New York, NY: Aldine de Gruyter.
- Kirk, S. A., & Kutchins, H. (1994a, June 20). Is bad writing a mental disorder? *New York Times*, pp. A17-20.
- Kirk, S. A., & Kutchins, H. (1994b). The myth of the reliability of DSM. *Journal of Mind and Behaviour*, 15(1-2), 71-86.
- Kirkpatrick, I., & Lucio, M. (1996). Introduction: The contract state and the future of public management. *Public Administration*, 74(1), 1-8.
- Kisely, S., Smith, M., Preston, N. J., & Xiao, J. (2005). A comparison of health service use in two jurisdictions with and without compulsory community treatment. *Psychological medicine*, 35(09), 1357-1367.
- Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness*, 16(1), 103-121.
- Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal*, 311(7000), 299-302.
- Kline, K. N. (2006). A decade of research on health content in the media: The focus on health challenges and sociocultural context and attendant informational and ideological problems. *Journal of Health Communication: International Perspectives*, 11(1), 43-59.
- Knights, D. & Morgan, G. (1991). Corporate strategy, organisations, and subjectivity: A critique. *Organisation Studies*, 12(2), 251-273.

- Koegel, P., Burnam, M. A., & Baumohl, J. (1996). The causes of homelessness. In J. Baumohl, (Ed.). *Homelessness in America* (pp. 24-33). Phoenix, AZ: The Oryx Press.
- Koenig, H. G. (2001). Exploring psychobiological, psychosocial, and cultural aspects of patient care: The international journal of psychiatry in medicine in the 21st Century. *International Journal of Psychiatry in Medicine, 30*(3), 195-198.
- Koppelman, N. E., & Bourjolly, J. N. (2001). Conducting focus groups with women with severe psychiatric disabilities: A methodological overview. *Psychiatric Rehabilitation Journal, 25*(2), 142-151.
- Krueger, R. A. (1998). *Analysing and reporting focus group results* (Vol. 6). Thousand Oaks, CA: Sage Publications.
- Krueger, R. A., & Casey, M. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago Press.
- Kukler, B. (1999). *Northern region community support work services outcomes project*. Unpublished paper. Auckland, New Zealand: Northern Regional Health Authority.
- Kukler, B., Cartman, B., Coats, R., Kingi, P., Millson, M., & Warmington, J. (1998). *Community support work: Principles and values*. Auckland, New Zealand: Northern Regional Health Authority.
- Kutchins, H., & Kirk, S. (1997). *Making us crazy, DSM: The psychiatric bible and the creation of mental disorders*. New York, NY: Free Press.
- Labonte, R. (1990). Empowerment: Notes on community and professional dimensions. *Canadian Research on Social Policy, 26*, 64-75.
- Labonte, R. (1996). *Community development in the public health sector: The possibilities of empowering relationships between state and civil society* (Doctoral thesis). York University, Toronto, Canada.

- Labonte, R. (1997). *Power, participation and partnership for health promotion*. Melbourne, Australia: Victorian Health Promotion Foundation.
- Laing, R. D. (1960). *The divided self: An existential study in sanity and madness*. London, England: Penguin.
- Lake, J. (2007). Emerging paradigms in medicine: Implications for the future of psychiatry. *The Journal of Science and Healing*, 3(5), 467-477.
- Lakoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago, IL: University of Chicago Press.
- Lam, M., Pearson, V. , Ng, R., Chiu, C., Law, C. W., & Chen, E. Y. (2011). What does recovery from psychosis mean? Perceptions of young first-episode patients. *International Journal of Social Psychiatry*, 57(6), 580-587.
- Lambert, S. D., & Loisel (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, 62(2), 228–237.
- Lammers, J. C., Barbour, J. B., & Duggan, A. P. (2003). Organisational forms of the provision of health care: An institutional perspective. In T. L. Thompson, A. Dorsey, K. I. Miller, & R. Parrott (Eds.), *The handbook of health communication* (pp. 319-345). Mahwah, NJ: Lawrence Erlbaum Associates.
- Lammers, J. C. (2011). How institutions communicate: Institutional messages, institutional logics and organisational communication. *Management Communication Quarterly*, 25(1), 154-182.
- Lapsley, H. (2004, May). *Bridging the gap from researching recovery to developing recovery indicators*. Paper presented at the VICSERV Conference, *Recovery: Challenging the Paradigm*. Melbourne, Australia.
- Lapsley, H., & Nikora, L. (2002). *Kia mauri tau: Narratives of recovery from disabling mental health problems*. Wellington, New Zealand: Mental Health Commission.

- Lapsley, H., & Yee, B. (2004). *Journeys towards equality: Taking stock of New Zealand's efforts to reduce discrimination against people with experience of mental illness*. Wellington, New Zealand: Mental Health Commission.
- Larner, W., & Craig, D. (2005). After neoliberalism? Community activism and local partnerships in Aotearoa New Zealand. *Antipode*, 37(3), 402-424.
- Laughlin, R. C. (1991). Environmental disturbances and organisational transitions and transformations: Some alternative models. *Organisation Studies*, 12(2), 209-232.
- Lawrence, T. B., & Suddaby, R. (2006). Institutions and institutional work. In S. R. Clegg, C. Hardy, T. B. Lawrence & W. R. Nord (Eds.), *Sage handbook of organisational studies* (2nd ed.) (pp. 215-254). London, England: Sage Publications.
- Lawrence, T., Suddaby, R., & Leca, B. (2011). Institutional work: Refocusing institutional studies of organisation. *Journal of Management Inquiry*, 20(1), 52-58.
- Lawrence, T. B., Leca, B., & Zilber, T. B. (2013). Institutional work: Current research, new directions and overlooked issues. *Organisation Studies*, 34(8), 1023-1033.
- Leclercq-Vandelannoitte, A. (2011). Organisations as discursive constructions: A Foucauldian approach. *Organisation Studies*, 32(9), 1247-1271.
- Leff, J. P. (Ed.). (1997). *Care in the community: Illusion or reality?* London, England: John Wiley & Son.
- Lehman, A. F. (2000). Putting recovery into practice: A commentary on "What recovery means to us". *Mental Health Journal*, 36(3), 329-331.
- Leibrich, J. (1988). *An outside chance: Community care for people discharged from psychiatric hospitals in Britain*. Auckland, New Zealand: Health Services Research and Development Unit and the Mental Health Programme, Department of Health.
- Leibrich, J. (1997). The doors of perception. *Australian and New Zealand Journal of Psychiatry*, 31(1), 36-45.

- Leibrich, J. (1998, November). *Taking off the strait jacket*. Presentation on the publication of *A gift of stories*, The Grand Hall, Parliament Buildings, Wellington, New Zealand.
- Leibrich, J. (2000a). Discovering the life you want. In J. Leibrich, (Ed.), *A gift of stories* (pp. 173-192). Wellington, New Zealand: Otago University Press.
- Leibrich, J. (Ed.). (2000b). *A gift of stories*. Wellington, New Zealand: Otago University Press.
- Leibrich, J. (2002). Making space: Spirituality and mental health. *Mental Health, Religion & Culture*, 5(2), 143-162.
- Leibrich, J., & Carson, J. (2012). Remarkable lives: Julie Leibrich in conversation with Jerome Carson, *Mental Health and Social Inclusion*, 16(4), 175-180.
- Leonard, D. (1999). Care in the community: Illusion or reality? *Australian and New Zealand Journal of Psychiatry*, 33(1), 134-135.
- Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues*, 2, 34-46.
- Lewis, L. (2005). The civil society sector: A review of critical issues and research agenda for organisational communication scholars. *Management Communication Quarterly*, 19(2), 238–267.
- Lewis, S., Passmore, J., & Cantore, S. (2008). Appreciative inquiry: Applying positive psychology in real world change. *Industrial and Commercial Training*, 40(4), 175-181.
- Ley, A., Roberts, G., & Willis, D. (2010). How to support peer support: Evaluating the first steps in a healthcare community. *Journal of Public Mental Health*, 9(1), 16-25.
- Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, 1(3), 275-289.
- Lincoln, Y. S. and Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, 1986(30), 73–84.

- Lonti, Z., & Gregory, R. (2007). Accountability or countability? Performance measurement in the New Zealand public service, 1992-2002. *The Australian Journal of Public Administration*, 66(4), 468-484.
- Lord, J., & Dufort, E. (1996). Power and oppression in mental health. *Canadian Journal of Community Mental Health*, 15(2), 5-11.
- Lord, J., Ochacka, J., Czarny, W., & MacGillivray, H. (1998). Analysis of change within a mental health organisation: A participatory process. *Psychiatric Rehabilitation Journal*, 21(4), 327-339.
- Lord, J., Ochacka, J., Nelson, G., & Choma, B. (2004). Shifting the paradigm in community mental health: Towards empowerment and community. *The Canadian Journal of Program Evaluation*, 19(3), 185-187.
- Lounsbury, M. (2001). Institutional sources of practice variation: Staffing college and university recycling programs. *Administrative Science Quarterly*, 46(1) 29–56.
- Lounsbury, M. (2009). The problem of order revisited: Towards a more critical institutional perspective. In R. Westwood & S. Clegg (Eds.), *Debating organisation: Point-counterpoint in organisation studies* (pp. 210-219). Oxford, United Kingdom: John Wiley & Sons.
- Ludema, J. D., Wilmot, T. B., & Srivastva, S. (1997). Organisational hope: Reaffirming the constructive task of social and organisational inquiry. *Human Relations*, 50(8), 1015-1052.
- Luhrmann, T. M. (2000). *Of two minds: The growing disorder in American psychiatry*. New York, NY: Alfred A. Knopf.
- Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Communication*, 6(1), 55-67.
- Luske, B. (1990). *Mirrors of madness: Patrolling the psychic border*. New York, NY: Aldine de Gruyter.
- Maguire, S., & Hardy, C. (2009). Discourse and deinstitutionalisation: The decline of DDT. *Academy of Management Journal*, 52(1), 148-178.

- Mancini, M. A., Hardiman, E. R. & Lawson, H. A. (2005). Making sense of it all: Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 29(1), 48-55.
- Manderscheid, R. W. (2006). Some thoughts on the relationships between evidence based practices, practice based evidence, outcomes, and performance measures. *Administration and Policy in Mental Health*, 33(6), 646-647.
- Marbrook, J. (Producer and Director). (2012). *Mental notes*. Auckland, New Zealand: Vfilms.
- Markham, A. (1996). Designing discourse: A critical analysis of strategic ambiguity and workplace control. *Management Communication Quarterly*, 9(4), 389-421.
- Martyn D. (2002). *The experiences and views of self-management of people with a schizophrenia diagnosis*. London, England: NSF Self-Management Project.
- Mason, K. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or releases on leave of certain classes of patients*. Wellington, New Zealand: Ministerial Inquiry, Ministry of Health.
- Mason, K. (1996). *Inquiry under section 47 of the Health and Disability Services Act 1993, in respect of certain mental health services*. Wellington, New Zealand: Ministerial Inquiry, Ministry of Health.
- May R. (2001). *Understanding psychotic experience and working towards recovery*. Bradford, England: Bradford District Community Trust.
- May, R. (2004). *Psychological interventions in early psychosis services: A treatment handbook*. New York, NY: John Wiley.
- May, S., & Mumby, D. K. (Eds.). (2005). *Engaging organisational communication theory and research: Multiple perspectives*. Thousand Oaks, CA: Sage Publications.

- Mayers, C. (2000). Quality of life: Priorities for people with enduring mental health problems. *British Journal of Occupational Therapy*, 63(12), 591–596.
- McAllister, M., & Chatterton, R. (1996). Clozapine: Exploring clients' experiences of treatment. *The Australian & New Zealand Journal of Mental Health Nursing*, 5(3), 136-142.
- McCashen, W. (2005). *The strengths approach: A strengths-based resource for sharing power and creating change*. Melbourne, Australia: Saint Luke's Innovative Resources.
- McGinley, J. (2005, September 16). Thoughts on recovery [online discussion forum]. Retrieved from <http://www.scottishrecovery.net>.
- McHoul, A., & Grace, W. (1988). *A Foucault primer: (NZ ed.)*. Dunedin, New Zealand: University of Otago Press.
- McKegg, K. & Oakden, J. (2009). *Characteristics of good peer support: Report prepared for Wellink Trust*. Wellington, New Zealand: Knowledge Institute.
- McKnight, J. L. (1987). Regenerating community. *Social Policy*, 17(3), 54-58.
- McMorland, J., Kukler, B., Murray, L., & Warriner, R. (2008). Partnerships in development: Developments in mental health service provision in New Zealand: A case study. *Journal of Employment Relations*, 33(1), 19-37.
- McPhee, R. D. (1985). Formal structure and organisational communication. In R. D. McPhee & P. K. Tompkins (Eds.), *Organisational communication: Traditional themes and new directions* (pp. 149-178). Thousand Oaks, CA: Sage Publications.
- Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134-141.
- Mead, S. (2005). *Intentional peer support: An alternative approach*. Plainfield, NH: Fishery Mead Consulting.
- Melling, J. (1999). Accommodating madness: New research in the social history of insanity and institutions. In J. Melling, & B. Forsythe (Eds.), *Insanity*,

institutions and society, 1800- 1914: A social history of madness in comparative perspective (pp. 1-30). London, England: Routledge.

Mental Health Advocacy Coalition (MHAC). (2008). *Destination recovery: Te ūnga ki uta: Te oranga*. Auckland, New Zealand: Mental Health Foundation of New Zealand.

Mental Health Commission. (1997a). *Moving forward: The national mental health plan for more and better services*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (1997b). *Discrimination against people with experiences of mental illness* (Discussion paper). Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (1998a). *The blueprint for mental health services in New Zealand*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (1998b). *Te mahere o nga ara haere: Map of the journeys towards equality respect and rights for people who experience mental illness*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (2001). *Open all hours? A review of crisis mental health services*. Wellington: Mental Health Commission.

Mental Health Commission. (2004a). *Seclusion in New Zealand mental health services*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (2004b). *Second mental health plan: Report of the sector leaders' forum*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (2007a). *Te haererenga mo te whakaoranga: The journey of recovery for the New Zealand mental health sector, 1996-2006*. Wellington, New Zealand: Mental Health Commission.

Mental Health Commission. (2007b). *Te hononga 2015: Connecting for greater well-being*. Wellington, New Zealand: Mental Health Commission.

- Mental Health Commission. (2011). *Measuring inclusion: People with experience of mental illness and addiction*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2011b). *Recovery meanings and measures: A scan of the literature*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2012a). *Blueprint II: Improving mental health and well-being for all New Zealanders: How things need to be*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2012b). *Blueprint II: Improving mental health and well-being for all New Zealanders: Making change happen*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Foundation. (1987). *Briefing to Minister of Social Welfare*. Wellington, New Zealand: Mental Health Foundation.
- Meriläinen, S., Tienari, J., Thomas, R., & Davies, A. (2004). Management consultant talk: A cross-cultural comparison of normalizing discourse and resistance. *Organisation, 11*(4), 539-564.
- Messner, M., Clegg, S., Kornberger, M. (2008). Critical Practices in Organisations. *Journal of Management Inquiry, 17*(2), 68-82.
- Meyer, J. W., & Rowan, B. (1977). Institutionalised organisations: Formal structure as myth and ceremony. *American Journal of Sociology, 83*(2), 340-363.
- Meyer, J. W., & Rowan, B. (1991). Institutionalized organisations: Formal structure as myth and ceremony. In W. W. Powell, & P. J. DiMaggio (Eds.), *The new institutionalism in organisational analysis* (pp. 41-62). Chicago, IL: University of Chicago Press.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oakes, CA: Sage Publications.
- Miller, P., O'Leary, T., & Boland, R. J. (1987). Accounting and the construction of the governable person: Discussion. *Accounting, Organisations and Society, 12*(3), 235-265.

- Miller, P., & Rose, N. (1988). The Tavistock experiment: The government of subjectivity and social life. *Sociology*, 22(2), 171-192.
- Miller, S., Duncan, B., Johnson, L., & Hubble, M. (2000). Toward an outcome informed therapeutic practice. *Psychotherapy in Australia*, 6(2), 30-36.
- Ministerial Advisory Committee. (1988). *Puao te ata tu (Day break). Ministerial advisory committee on a Māori perspective for the Department of Social Welfare*. Wellington, New Zealand: Ministry of Social Development.
- Ministry of Health. (1992). *Mental Health (Compulsory Assessment and Treatment) Act 1992*, Public Act 1992 No 46. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2001a). *Feedback on national mental health non-clinical services: Consultation report*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2001b). *Building on strengths: A guide for action: A new approach to promoting mental health in New Zealand/Aotearoa*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2003). *National plan: Project to counter stigma and discrimination associated with mental illness*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2005). *Te tahuu: Improving mental health 2005-2015: The second New Zealand mental health and addiction plan*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2006). *Te kokiri: The mental health and addiction action plan 2006–2015*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2012a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington, New Zealand: Ministry of Health.

- Ministry of Health. (2012b). *Guidelines for the role and function of duly authorised officers: Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2012c). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2013). *Office of the Director of Mental Health annual report 2012*. Wellington, New Zealand: Ministry of Health.
- Ministry of Social Development. (2001). *Communities and government: Potential for partnership: Whakato-pu-whakaaro*. Wellington, New Zealand: Ministry of Social Development.
- Minkler, M. (1990). Improving health through community organisation. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), *Health behaviour and health education* (pp. 257-287). San Francisco, CA: Jossey-Bass.
- Minkler, M. (2000). Using participatory action research to build healthy communities. *Public Health Reports: Focus on Healthy Communities*, 115(2/3), 191-197.
- Minkler, M., & Cox, K. (1980). Creating critical consciousness in health: applications of Freire's philosophy and methods to the health care setting. *International Journal of Health Services*, 10(2), 311-322.
- Minkowitz, T. (2006). *No-force advocacy by users and survivors of psychiatry*. Wellington: Mental Health Commission.
- Mitchell, L. (2000). *Mental health consumer participation: A New Zealand perspective*. Wellington, New Zealand: Mental Health Commission.
- Mizruchi, M. S., & Fein, L. C. (1999). The social construction of organisational knowledge: A study of the uses of coercive, mimetic, and normative isomorphism. *Administrative Science Quarterly*, 44(4), 653-683.
- Moncrieff, J. (2007). Co-opting psychiatry: The alliance between academic psychiatry and the pharmaceutical industry. *Epidemiology and Psychiatric Sciences*, 16(03), 192-196.

- Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. New York, NY: Palgrave Macmillan.
- Moncrieff, J., Cohen, D., & Porter, S. (2003). The psychoactive effects of psychiatric medication: The elephant in the room. *Journal of Psychoactive Drugs*, 45(5), 409-415.
- Moncrieff, J., & Crawford, M. J. (2001). British psychiatry in the 20th century: Observations from a psychiatric journal. *Social Science & Medicine*, 53(3), 349-356.
- Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., & Priebe, S. (2007). Social exclusion and mental health: Conceptual and methodological review. *The British Journal of Psychiatry*, 191(6), 477-483.
- Morgan, D. L., (1997). *Focus groups as qualitative research* (2nd ed., Vol. 16). Thousand Oaks, CV: Sage Publications.
- Morgan, D. L. (1998). *The focus group guidebook* (Vol. 1). Thousand Oaks, CA: Sage Publications.
- Morrill, C., Zald, M. N., & Rao, H. (2003). Covert political conflict in organisations: Challenges from below. *Annual review of sociology*, 391-415.
- Morrison, D. E. (1998). Good and bad practice in focus group research. In V. Nightingale and K. Ross (Eds.), *Critical readings: Media and audiences* (pp. 111-130). Maidenhead, England: Open University Press.
- Morrison, L. J. (2006). A matter of definition: Acknowledging consumer/survivor experiences through narrative. *Radical Psychology: A Journal of Psychology, Politics & Radicalism*, 5, 30-36.
- Mosher, L. R. (1999). Are psychiatrists betraying their patients? *Psychology Today*, 32(5), 40-42.
- Mosher, L. R., & Boyle, M. (2004). Rethinking the mental health industry. *Ethical Human Psychology and Psychiatry*, 6(3), 237-238.
- Mosher, L. R., & Vallone, R. (1995). The treatment of acute psychosis without neuroleptics: Six-week psychopathology outcome data from the Soteria Project. *International Journal of Social Psychiatry*, 45(3), 157-173.

- Mountain, D., & Shah, P. J. (2008). Recovery and medical model: Yes, science does matter. *Advances in Psychiatric Treatment*, 14(5), 398.
- Mumby, D. K. (1988). *Communication and power in organisations: Discourse, ideology and domination*. Norwood, NJ: Ablex Publishing Corporation.
- Mumby, D. K. (1997). The problem of hegemony: Rereading Gramsci for organisational communication studies. *Western Journal of Communication*, 61(4), 343-375.
- Mumby, D. K. (2005). Theorising resistance in organisation studies: A dialectical approach. *Management Communication Quarterly*, 19(1), 19-44.
- Mumby, D. (2008). Organisational communication: Critical approaches. In W. Donsbach (Ed.), *Encyclopaedia of Communication* (Vol. 8) (pp. 3427-3433). Washington, DC: International Communication Association.
- Mumby, D. K., & Stohl, C. (1996). Disciplining organisational communication studies. *Management Communication Quarterly*, 10(1), 50-72.
- Mumby, D. K., & Stohl, C. (2007). Re-disciplining organisational communication studies: A response to Broadfoot and Munshi. *Management Communication Quarterly*, 21(2), 268-280.
- Nadesan, M. H. (2005). *Constructing autism: Unravelling the 'truth' and understanding the social*. London, England: Routledge.
- Nairn, R. (1999). Does the use of psychiatrists as sources of information improve media depictions of mental illness? A pilot study. *Australian and New Zealand Journal of Psychiatry*, 33(4), 583-589.
- Nairn, R., Coverdale, S., & Coverdale, J. (2011). A framework for understanding media depictions of mental illness. *Academic Psychiatry*, 35(3), 202-6.
- Nelson, J. S., Megill, A., & McCloskey, D. N. (Eds.). (1987). *The rhetoric of the human sciences: Language and argument in scholarship and public affairs*. Madison, WI: University of Wisconsin Press.
- Nerlich, B., Dingwall, R., & Martin, P. (Eds.). (2004). Genetic and genomic discourses at the dawn of the 21st century. *Discourse & Society*, 15(4), 363-491.

- Nettleton, S. (1995). Medicine as culture: Illness, disease and the body in western societies. *Sociology*, 29(1), 174-175.
- Newman, F. (1999). Does a story need a theory? (Understanding the methodology of narrative therapy). In D. Fee (Ed.), *Pathology and the postmodern: Mental illness as discourse and experience* (pp. 248-262). London, England: Sage Publications.
- Nikora, L. W. (Ed.). (1993). Cultural justice and ethics. Proceedings of a symposium held at the *Annual Conference* of the New Zealand Psychological Society. University of Victoria, Wellington, 23-24 August 1993 (pp. 1-75).
- Noir, C., & Walsham, G. (2007). The great legitimizer: ICT as myth and ceremony in the Indian healthcare sector. *Information Technology & People*, 20(4), 313-333.
- Oaks, D. (2006). Letters: The evolution of the survivor movement. *Psychiatric Services*, 57(8), 1212-1212.
- O'Brien, P., & Sullivan, M. (Eds.). (2005). *Allies in emancipation: Shifting from providing service to being of support*. Melbourne, Australia: Thomson Dunmore Press.
- O'Brien, A. J., & Golding, C. G. (2003). Coercion in mental healthcare: The principle of least coercive care. *Journal of Psychiatric and Mental Health Nursing*, 10(2), 167-173.
- O'Brien, A. J., & Kar, A. (2006). The role of second health professionals under New Zealand mental health legislation. *Journal of Psychiatric and Mental Health Nursing*, 13(3), 356-363.
- O'Brien, M., Sanders, J., & Tennant, M. (2009). *The New Zealand non-profit sector and government policy*. Wellington, New Zealand: Office for the Community and Voluntary Sector.
- O'Brien, A. J., McKenna, B. G., & Kydd, R. R. (2009). Compulsory community mental health treatment: Literature review. *International Journal of Nursing Studies*, 46(9), 1245-1255.

- Ochaka, J., Nelson, G., & Lord, J. (1999). Organisational change towards the empowerment: Community integration paradigm in community mental health. *Canadian Journal of Community Mental Health*, 18(2), 59-72.
- Office of the Privacy Commissioner. (1994). *Health Information Privacy Code 1994*. Wellington, New Zealand: Privacy Commission.
- O'Hagan, M. (1991). *Stopovers on my way home from Mars: A Winston Churchill Fellowship report on the psychiatric survivor movement in the USA, Britain and the Netherlands*. Auckland, New Zealand: ANOPS.
- O'Hagan, M. (1994, September). *The removal and return of competence and power to consumers*. Keynote address for the 4th Annual Australian and NZ Mental Health Services (THEMHS) Conference: Surviving Mental Illness: Families, Consumers and the Mental Health System. Melbourne, Australia.
- O'Hagan M. (1999, November). *Six challenges to the mental health sector*. Paper presented at the Mental Health Commission Conference: Realising Recovery. Wellington, New Zealand.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington, New Zealand: Mental Health Commission.
- O'Hagan, M. (2003). Living well. *Openmind*, 118(Nov/Dec), 16-17
- O'Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia? *Advances in Mental Health*, 3(1), 5-7.
- O'Hagan, M. (2009a). The colonisation of recovery. *Openmind*, 156(March/April), 20.
- O'Hagan, M. (2009b). Recovery. *Mental Health Today*, (Dec 2008), 16-17.
- O'Hagan, M. (2009c). Leadership for empowerment and equality: A proposed model for mental health user/survivor leadership. *The International Journal of Leadership in Public Services*, 5(4), 34-43.
- O'Hagan, M. (2010). *Making sense of madness from the inside*. Retrieved from http://rethink.org.nz/?page_id=529.

- O'Hagan, M. Reynolds, P., & Smith, C. (2012). Recovery in New Zealand: An evolving concept? *International Review of Psychiatry*, 24(1), 56–63.
- Oliver, C. (1992). The antecedents of deinstitutionalization. *Organisation Studies*, 13(4), 563–588.
- Oliver, C. (1997). Sustainable competitive advantage: Combining institutional and resource-based views. *Strategic Management Journal*, 18(9), 697-713.
- Oliver, M. (1996). *Understanding disability: From theory to practice*. London, England: McMillan.
- Oliver, M. (1998). Theories of disability in health practice and research. *British Medical Journal*, 317(7170), 1446-1449.
- Oliver, M. (1999). Capitalism, disability and ideology: A materialist critique of the normalization principle. In R. Flynn, & R. Lemay (Eds.). *A quarter-century of normalization and social role valorisation: evolution and impact* (pp. 163-174). Ottawa, Canada: University of Ottawa Press.
- Onken, S. J., Dumont, J. M., Ridgway, P., Dorman, D. H. & Ralph, R. O. (2000). *Mental health recovery: What helps and what hinders?* Alexandria, VA: NASMHPD, National Technical Assistance Centre for State Mental Health Planning.
- O'Reilly, D., & Reed, M. (2011). The grit in the oyster: Professionalism, managerialism and leaderism as discourses of UK public services modernisation. *Organisation Studies*, 32(8), 1079-1101.
- Owen, W. F. (1984). Interpretive themes in relational communication. *Quarterly Journal of Speech*, 70(3), 274-287.
- Oyebode, F. (2004). Invited commentary on: The rediscovery of recovery. *Advances in Psychiatric Treatment*, 10(1), 48-49.
- Parker, A., & Tritter, J. (2006). Focus group method and methodology: Current practice and recent debate. *International Journal of Research and Method in Education*, 29(1), 23-37.

- Parsons, T. (1975). The sick role and the role of the physician reconsidered. The Milbank Memorial Fund Quarterly. *Health & Society*, 53(3), 257-278.
- Paterson, R. (2002). The patients' complaints system in New Zealand. *Health Affairs*, 21(3), 70-9.
- Pearson, A. (2000, March). *Reclaiming Bedlam: The challenge of shifting the paradigm of mental illness*. Keynote address at Building Bridges Conference. Auckland, New Zealand. Retrieved from <http://www.keepwell.com/pdf>.
- Pearson, A. (2001, July). *Where we have come from, where are we going to: Visioning for people pursuing recovery and partnership after mental illness*. Keynote address presented at NSW CAG Conference: Forging our Future. Sydney, Australia.
- Pearson, A. (2002, August). *There's no health without mental health: Critical issues for workforce development and service delivery*. Paper presented at the TheMHS Conference, Sydney. Retrieved from www.keepwell.co.nz.
- Pearson, A. (2004, May). *Recovery: Challenging the paradigm: A consumer perspective*. Paper presented at the Vicserve Conference. Melbourne, Australia. Retrieved from www.keepwell.co.nz.
- Perkins, R. (1999, September). *The individual's journey: Recovery and service provision*. Presentation to Good Practices in Community Nursing Conference. Manchester, United Kingdom.
- Perkins, R., & Repper, J. (2003). *Social inclusion and recovery: A model for mental health practice*. Kent, United Kingdom: Baillière Tindall.
- Perkins, R., & Repper, J., (2013). Prejudice, discrimination and social exclusion: reducing the barriers to recovery for people diagnosed with mental health problems in the United Kingdom. *Neuropsychiatry*, 3(4), 377-384.
- Perrow, C. (1986). *Complex Organisations: A Critical Essay* (3rd Ed.). New York, NY: Random House.

- Pescosolido, B., Wright, E., & Sullivan, W. P. (1995). Communities of care: A theoretical perspective on case management models in mental health. *Advances in Medical Sociology, 6*, 37-39.
- Pescosolido, B. A., Monahan, J., Link, B. G., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health, 89*(9), 1339-1345.
- Peters, J. (2009). *The real KeyWe Way story: A report prepared for Wellink Trust*. Wellington, New Zealand: Wellink (Te Hononga Ora).
- Peters, J. (2010). *Frontline: The community mental health and addiction sector at work in New Zealand*. Wellington, New Zealand: Platform Trust.
- Petersen, A. R. (1996). Risk and the regulated self: The discourse of health promotion as politics of uncertainty. *The Australian and New Zealand Journal of Sociology, 32*(1), 44-57.
- Petersen, A. (1997). Risk, governance and the new public health. In A. Petersen & R. Bunton (Eds.), *Foucault, health and medicine*. London, England: Routledge.
- Phillips, N. (2009). Discourse or institution? Institutional theory and the challenge of critical discourse analysis. In R. Westwood, & S. Clegg (Eds.), *Debating organisation: Point-counterpoint in organisation studies* (pp. 210-231). Oxford, United Kingdom: John Wiley & Sons.
- Phillips, N., Lawrence, T. B., & Hardy, C. (2004). Discourse and institutions. *Academy of Management Review, 29*(4), 635-652.
- Philo, G. (Ed.). (1996). *Media and mental distress*. London, England: Longman.
- Pierret, J. (1993). Constructing discourses about health and their social determinants. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease* (pp. 9-26). London, England: Routledge.
- Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future? *Journal of Mental Health, 11*(6), 585-594.

- Pilgrim, D. (2005). Protest and co-option: The voice of mental health service users. In A. Bell, & P. Lindley (Eds.), *Beyond the water towers: The unfinished revolution in mental health services 1985–2005* (pp. 17-26). United Kingdom: The Sainsbury Centre for Mental Health.
- Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science & Medicine*, 65(3), 536–547.
- Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, 8(3), 261-274.
- Pilgrim, D., & Rogers, A. (1994). Something old, something new . . . : Sociology and the organisation of psychiatry. *Sociology*, 28(2), 521-538.
- Pilgrim, D., & Rogers, A. (1999). *A sociology of mental health and mental illness* (2nd ed.). Buckingham, United Kingdom: Open University Press.
- Pilgrim, D., & Rogers, A. (2005a). Social psychiatry and sociology. *Journal of Mental Health*, 14(4), 317-320.
- Pilgrim, D., & Rogers, A. (2005b). The troubled relationship between psychiatry and sociology. *International Journal of Social Psychiatry*, 51(3), 228-241.
- Pilgrim, D., & Rogers, A. (2005c). Psychiatrists as social engineers: A study of an anti-stigma campaign. *Social Science & Medicine*, 61(12), 2546–2556.
- Pilgrim, D., & Rogers, A. (2009). Survival and its discontents: The case of British psychiatry. *Sociology of Health & Illness*, 31(7), 947-961.
- Pilgrim, D., Kinderman, P., & Tai, S. (2008). Taking stock of the bio psychosocial model in the field of 'mental health care'. *Journal of Social and Psychological Sciences*, 1(2), 1.
- Pincus, H A., Henderson, B., Blackwood, D., & Dial, T. (1993). Trends in research in two general psychiatric journals in 1969-1990: Research on research. *The American Journal of Psychiatry*, 150(1), 135.
- Pinfold, V. (2000). 'Building up safe havens . . . all around the world': Users' experiences of living in the community with mental health problems. *Health & Place*, 6(3), 201-212.

- Platform Trust. (2006). *NgOIT 2005 landscape survey*. Wellington, New Zealand: Platform Trust.
- Platform Trust. (2007). *NgOIT 2007 workforce survey*. Wellington, New Zealand: Platform Trust.
- Platform Trust. (2008). *NGO-DHB contracting environment*. Wellington, New Zealand: Platform Trust.
- Platz, G. N. (2006, August). *Recovery in connection*. Paper presented at TheMHS Reach Out, Connect Conference. Townsville, Australia.
- Platz, G., & Norris, H. (2005). A question of balance. *Mental Health Today*, July\August, 22-24.
- Porter, R. (1991). The history of psychiatry in Britain. *History of Psychiatry*, 2(7), 271–279.
- Postman, N. (1993). *Technopoly: The surrender of culture to technology*. New York, NY: Vintage Books.
- Powell, W. W., & DiMaggio, P. J. (Eds.). (1991). *The new institutionalism in organisational analysis*. Chicago, IL: University of Chicago Press.
- Powell, J. L. (2011). Towards a sociology of trust: Community care and managing diversity. *Sociology Mind*, 1(2), 27-32.
- Prichard, C. (2009). Blood on the tracks: Critically re-reading a government occupational health & safety inquiry. *Culture and Organisation*, 11(2), 97-110.
- Prior, L. (1993). *The social organisation of mental illness*. London, England: Sage Publications.
- Pulotu-Endemann, F. (2001). *Fonofale model of health*. Wellington, New Zealand: Health Promotion Forum, Ministry of Health.
- Punch, K. F. (1998). *Introduction to social research: Quantitative and qualitative approaches*. London, England: Sage Publications.
- Putnam, L., Nicotera, A. M., & McPhee, R. D. (2008). Introduction: Communication constitutes organisation. In L. Putnam, & A. M. Nicotera

- (Eds.), *Building theories of organisation: The constitutive role of communication* (pp. 1–19). New York, NY: Routledge.
- Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, 53(2), 108-122.
- Ramsden, I. (1997). Cultural safety: Implementing the concept: The social force of nursing and midwifery. In P. Te Whaiti, M. McCarthy, & A. Durie (Eds.), *Mai i rangiatea: Māori well-being and development* (pp. 113-125). Auckland, New Zealand: Auckland University Press.
- Ranz, J., & Mancini, A. (2008). Public psychiatrists' reports of their own recovery-oriented practices. *Psychiatric Services*, 59(1), 100-104.
- Rapp, C. A. (1998). *The Strengths model of case management for people with severe and persistent mental illness*. New York, NY: Oxford University Press.
- Rapp, C., Kisthardt, W., Gowdy, E., & Hansen, J. (1991, August). *Amplifying the consumer voice: Qualitative methods, empowerment and mental health research*. Paper presented at the Qualitative Methods in Social Work Research Conference. Albany, NY.
- Rappaport, J. (Ed.) (1984). *Studies in empowerment: Steps to the Issue*. New York, NY: Hawthorn Press.
- Rappaport, J. (1987). Terms of empowerment, exemplars of prevention: Towards a theory for community psychology. *American Journal of Community Psychology*, 15(2), 121-148.
- Rappaport, J. (1990). Research methods and the empowerment social agenda. In F. Chertok, & L. Jason (Eds.), *Research methods in psychology* (pp. 51-63). Washington, DC: American Psychological Association.
- Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology*, 23(5), 795-807.

- Rappaport, J. (2002). In praise of paradox: A social policy of empowerment over prevention. In T. A. Revenson et al. (Eds.), *A quarter century of community psychology: Readings from the American journal of community psychology* (pp. 121-145). New York, NY: Plenum Publishers.
- Read, J. [Jacob]. (2003a). *Emancipation songs: Consumers views on individual treatment participation in mental health care*. Hamilton, New Zealand: University of Waikato.
- Read, J. [Jacob]. (2003b). *Emancipation songs: Individual participation by service users in mental health care*. Wellington, New Zealand: Mental Health Commission.
- Read, J. [John]. (2005). The bio-bio-bio model of madness. *The Psychologist*, 18(10), 596-597.
- Read, J. [John]. (2007). Why promoting biological ideology increases prejudice against people labelled "schizophrenic". *Australian Psychologist*, 42(2), 118-128.
- Read, J. [John], Bentall, R., & Mosher, L. (Eds.). (2004). *Models of madness: Psychological, social and biological approaches to schizophrenia*. Hove, England: Brunner-Routledge.
- Read, J. [John], & Dillon, J. (Eds.). (2013). *Models of madness: Psychological, social and biological approaches to psychosis* (2nd ed.). London, England: Routledge.
- Reason, P. (2000). *Action research as spiritual practice*. Paper presented at the University of Surrey Learning Community Conference, May 4-5. EDUCAUSE. Surrey, United Kingdom.
- Reay, T., & Hinings, C. B. (2005). The recomposition of an organisational field: Health care in Alberta. *Organisation Studies*, 26(3), 351-384.
- Reay, T., & Hinings, C. (2009). Managing the rivalry of competing institutional logics. *Organisation Studies*, 30(6), 629-652.

- Reed, M. (1998). Organisational analysis as discourse analysis: A critique. In D. Grant, & C. Osrick (Eds.), *Discourse and organisation* (pp. 193-213). London, England: Sage Publications.
- Repper, J., & Perkins, R. (1995). The deserving and the undeserving: Selectivity and progress in a community care service. *Journal of Mental Health, 4*(5), 483-495.
- Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. London: Baillière Tindall.
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services, *Journal of Mental Health, 20*(4), 392-411.
- Ridgway, P. (2001). Restorying psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 355-343.
- Roberts, G., & Wolfson, P. (2004). The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment, 10*(1), 37-48.
- Robertson, A. (2001). Biotechnology, political rationality and discourses on health risk. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine, 5*(3), 293-310.
- Roen, K. (1999). *Community support work research project*. Christchurch, New Zealand: Health Funding Authority.
- Rogers, A., Pilgrim, D., & Lacey, R. (1993). *Experiencing psychiatry: Users' views of services*. Basingstoke, United Kingdom: Macmillan.
- Romme M., & Escher S. (2000). *Making sense of voices*. London, England: Mind Publications.
- Roper, C., & Pearson, A. (1999, September). *The lyre bird and the huia: Voicing song-dreams*. Keynote address at 9th Annual TheMHS Conference: Whose Dreams? Whose Realities? Melbourne, Australia.
- Rose, N. (1990). *Governing the soul: The shaping of the private self*. Florence, KY: Taylor & Frances/Routledge
- Rose, N. (1996). Psychiatry as a political science: Advanced liberalism and the administration of risk. *History of the Human Sciences, 9*(2), 1. -23.

- Rose, N. (1998). Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, psychology and law*, 5(2), 177-195.
- Rose, N. (1999). *Powers of freedom: Reframing political thought*. Cambridge, United Kingdom: Cambridge University Press.
- Rose, N. (2003). Neurochemical selves. *Society*, 41(1), 46-59.
- Rose, N. (2006). Disorders without borders? The expanding scope of psychiatric practice. *BioSocieties*, 1(4), 465-484.
- Rose, N., O'Malley, P., & Valverde, M. (2006). Governmentality. *Annual Review of Law and Social Science*, 2, 83-104.
- Rose, S. (1972). *The betrayal of the poor: The transformation of community action*. Cambridge, United Kingdom: Schenkman Books.
- Rose, S. (2000). Reflections on empowerment-based practice. *Social Work*, 45(5), 403-412.
- Rose, S., & Black, B. (1985). *Advocacy and empowerment: Mental health care in the community*. Boston: Routledge & Kegan Paul.
- Rose, D., Wykes, T., Leese, M., Bindman, J., & Fleischmann, P. (2003). Patients' perspective on electro-convulsive therapy: systematic review. *British Medical Journal*, 326(7403), 1363-1365.
- Rosenberg, S. D., & Mueser, K. (2008). Trauma and posttraumatic stress syndromes. In K. Mueser, & D. V. Jeste (Eds.), *Clinical handbook of schizophrenia* (pp. 447-458). New York, NY: Guildford Press.
- Royal College of Psychiatrists (1998). *Changing minds*. Unpublished policy document. (Available on request from Royal College of Psychiatrists.)
- Rudge, T., & Morse, K. (2001). Re-awakenings? A discourse analysis of the recovery from schizophrenia after medication change. *Australian and New Zealand Journal of Mental Health Nursing*, 10(2), 66-76.
- Rudegear, T. (2003). Being a psychiatrist will never be the same. *Incite: The Mental Health Journal of New Zealand*, 1(2), 17-19.
- Rush, B. (1812). *Medical inquiries and observations upon the disease of the mind*. Philadelphia, PA: Kimber & Richardson.

- Rushdie, S. (1991, December 12). *One thousand days in a balloon*. New York Times, 12.
- Saleebey, D. (2001). The diagnostic strengths manual. *Social Work, 42*(2), 183-187.
- Saleebey, D. (Ed.). (2002). *The strengths perspective in social work practice* (3rd ed.). Boston, MA: Allyn & Bacon.
- Salyers, M. P., & Macy, V. R. (2005). Recovery-oriented evidence-based practices: A commentary. *Community Mental Health Journal, 41*(1), 101-103.
- Salyers, M. P., Tsai, J., & Stultz, T. A. (2007). Measuring recovery orientation in a hospital setting. *Psychiatric Rehabilitation Journal, 31*(2), 131-137.
- Samson, C. (1995). Madness and psychiatry. In B. S. Turner (Ed.), *Medical power and social knowledge* (2nd ed., pp. 55-83). London, England: Sage Publications.
- Samuel, G., & Smith J. (2005). A step up. *Openmind* (Mind News) 135, 3.
- Sanders, J., O'Brien, M., Tennant, M., Sokolowski, S. W., & Salamon, L. M. (2008). *The New Zealand non-profit sector in comparative perspective*. Wellington, New Zealand: Office for the Community and Voluntary Sector.
- Sandweiss, S. (1998). The social construction of environmental justice. In D. Camacho (Ed.). *Environmental injustices, political struggles: Race, class and the environment* (pp. 31-58). Durham, NC: Duke University Press.
- Sarantakos, S. (1993). *Social research*. Melbourne, Australia: McMillan Education.
- Sarney, E. (1996, May 19). Living above the despair threshold. *Sunday Star-Times*, p. C3.
- Sass, L. (1994). *Madness and modernism: Insanity in the light of modern art, literature, and thought*. Cambridge, MA: Harvard University Press.
- Sawyer, A. M. (2005). From therapy to administration: Deinstitutionalisation and the ascendancy of psychiatric 'risk thinking'. *Health Sociology Review, 14*(3), 283-296.

- Sayce, L. (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. London, England: Macmillan.
- Sayce, L. (2001). Social inclusion and mental health. *Psychiatric Bulletin*, 25(4), 121–123.
- Scheff, T. J. (1974). The labelling theory of mental illness. *American Sociological Review*, 39(3), 444-452.
- Scheff, T. J. (1999). *Being mentally ill: A sociological theory* (3rd ed.). Chicago, IL: Aldine.
- Schneiberg, M., & Lounsbury, M. (2008). Social movements and institutional analysis. In R. Greenwood, C. Oliver, K. Sahlin-Andersson, & R. Suddaby (Eds.), *Sage handbook of organisational institutionalism*. Thousand Oaks, CA: Sage Publications.
- Schneider, B. (2010). Housing people with mental illnesses: The discursive construction of worthiness. *Housing, Theory & Society*, 27(4), 296-312.
- Schneider, A., & Ingram, H. (1993). Social construction of target populations: implications for politics and policy. *American Political Science Review*, 87(2), 334-348.
- Schneider, B., Scissons, H., Arney, L., Benson, G., Derry, J., Lucas, K., . . . & Sunderland, M. (2004). Communication between people with schizophrenia and their medical professionals: A participatory research project. *Qualitative Health Research*, 14(4), 562-577.
- Schneider, B., & Remillard, C. (2013). Caring about homelessness: How identity work maintains the stigma of homelessness. *Text & Talk*, 33(1), 95-112.
- Scott, A. L., Doughty, C., & Kahi, H. (2011). *Peer support practice in Aotearoa New Zealand*. Retrieved <http://www.mhc.govt.nz/publications/peer-support-practice-aotearoa-new-zealand>
- Scott, W. R. (2001). *Institutions and organisations* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Scott, W. R. (2008). Lords of the dance: Professionals as institutional agents. *Organisational Studies*, 29(2), 219-238.

- Scott, W. R., & Christensen, S. (Eds.). (1995). *The institutional construction of organisations: International and longitudinal studies*. Thousand Oaks, CA: Sage Publications.
- Scott, W. R., & Meyer, J. W. (Eds.). (1994). *Institutional environments and organisations: Structural complexity and individualism*. Thousand Oaks, CA: Sage Publications.
- Scott, W. R., Ruef, M., Mendel, P. J., & Caronna, C. A. (2000). *Institutional change and healthcare organisations: From professional dominance to managed care*. Chicago, IL: University of Chicago Press.
- Scull, A. (1977). *Decarceration: Community and the deviant: A radical view*. Englewood Cliffs, NJ: Prentice Hall.
- Scull, A. (1979). *Museums of madness: The social organisation of insanity in 19th century England*. Markham, Ontario: Penguin Books.
- Scull, A. (1993). *The most solitary of afflictions: Madness and society in Britain, 1700-1900*. New Haven, CT: Yale University Press.
- Scull, A. (1994). Somatic treatments and the historiography of psychiatry. *History of Psychiatry*, 5(1994), 1-12.
- Seale, C. (Ed.). (2004) *Health and the media*. Oxford, United Kingdom: Wiley-Blackwell.
- Selznick, P. (1984). *TVA and the grass roots: A study of politics and organisation*. Berkeley, CA: University of California Press.
- Selznick, P. (1996). Institutionalism "old" and "new". *Administrative Science Quarterly*, 41(2), 270-277.
- Seo, M-G., & Creed, W. E. (2002). Institutional contradictions, praxis and institutional change: A dialectic perspective. *Academy of Management Review*, 27(2), 222-247.
- Shaw, P. (2002). *Changing conversations in organisations: A complexity approach to change*. London, England: Routledge.

- Shepherd, G., Boardman, J., & Slade, M., (2008). *Making recovery a reality*. Policy paper, Sainsbury Centre for Mental Health, London, England, pp. 1-3
- Shorter, E. (1997). *A history of psychiatry from the era of the asylum to the age of Prozac*. Oxford, United Kingdom: Wiley & Sons.
- Sillence, J. (2001). Getting acceptance that radically new working practices are required: Institutionalization of arguments about change within a healthcare organisation. *Human Relations*, 54(11), 1421–1454.
- Silverman, D., & Bloor, M. (1990). Patient centred medicine, some sociological observations on its constitution, penetration, and cultural assonance. *Advances in Medical Sociology*, 1, 3-25.
- Simpson, A., McKenna, B., Moskowitz, A., Skipworth, J., & Barry-Walsh, J. (2003). *Myth and reality: The relationship between mental illness and homicide in New Zealand*. Auckland, New Zealand: Health Research Council of New Zealand.
- Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. New York, NY: Cambridge University Press.
- Sointu, E. (2005). The rise of an ideal: Tracing changing discourses of well-being. *The Sociological Review*, 53(2), 255-274.
- Sointu, E. (2006). Recognition and the creation of well-being. *Sociology*, 40(3), 493-510.
- Smith, M., Coleman, R., & Goodman, J. (2003). *First aid in psychosis*. Wellington, New Zealand: Keepwell Publications.
- Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: Values and costs. *Behavioural Sciences & the Law*, 31(1), 125-140.
- Sontag, S. (1977). *Illness as metaphor*. New York, NY: Farrar, Straus and Giroux,
- Sowers, W. (2005). Transforming systems of care: The American Association of Community Psychiatrists guidelines for recovery oriented services. *Community Mental Health Journal*, 41(6), 757-774.

- Spandler, H. (2007). From social exclusion to inclusion? A critique of the inclusion imperative in mental health. *Medical Sociology Online*, 2(2), 3-16.
- Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *The experience of recovery: Self reports by people with mental illness*. Boston, MA: Centre for Psychiatric Rehabilitation, Boston University.
- Spano, S. J. (2001). *Public dialogue and participatory democracy: The Cupertino community project*. New York, NY: Hampton Press.
- Spitzer, R. (1999). Harmful dysfunction and the DSM definition of mental disorder. *Journal of Abnormal Psychology*, 108(3), 430-432.
- Stewart, D. W., Shamdasari, P. N., & Rook, D. W. (2007). *Focus group theory and practice* (2nd ed., Vol. 20). Thousand Oaks, CA: Sage Publications.
- Stewart, J. (2007). Managing across boundaries: The problem of conflicting values. *Third Sector Review*, 13(2), 71-85.
- Stohl, C., & Cheney, G. (2001). Participatory processes \ paradoxical practices. *Management Communication Quarterly*, 14(3), 349-407.
- Strang, D., & Meyer, J. W. (1993). Institutional conditions for diffusion. *Theory and Society*, 22(4), 487-511.
- Stringer, E. T. (1996). *Action research: A handbook for practitioners*. Thousands Oaks, CA: Sage Publications.
- Stromwall, L. K., & Hurdle, D. (2003). Psychiatric rehabilitation: An empowerment-based approach to mental health services. *Health & Social Work*, 28(3), 206-213.
- Suchman, M. (1995). Managing legitimacy: Strategic and institutional approaches. *Academy of Management Review*, 20(3), 571-610.
- Suddaby, R., & Greenwood, R. (2001). Colonising knowledge: Commodification as a dynamic of jurisdictional expansion in professional service firms. *Human Relations*, 54(7), 933-953.
- Suddaby, R. (2010). Challenges for institutional theory. *Journal of Management Inquiry*, 19(1), 14-20.

- Sullivan, W. P. (1992). Reclaiming the community: The strengths perspective and deinstitutionalisation. *Social Work, 37*(3), 204-209.
- Sullivan, W. P. (1994). A long and winding road: The process of recovery from severe mental illness. *Innovations & Research in Clinical Services, Community Support and Rehabilitation, 3*(3), 19-27.
- Susser, E., Conover, S., & Struening E. L. (1990). Mental illness in the homeless: Problems of epidemiologic method in surveys of the 1980s. *Community Mental Health Journal, 26*(5), 391-414.
- Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal, 29*(4), 311-314.
- Swingewood, A. (2000). *A short history of sociological thought*. Basingstoke, United Kingdom: Macmillan.
- Szasz, T. (1960). The myth of mental illness. *American Psychologist, 15*(2), 113-118.
- Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct* (revised ed.). New York, NY: Perennial.
- Szmukler, G., & Rose, N. (2013). Risk assessment in mental health care: Values and costs. *Behavioural Science and the Law, 31*(1), 125-140.
- Taylor, B. C. (2004). Postmodern theory. In D. K. Mumby, & S. K. May (Eds.), *Engaging organisational communication theory and research: Multiple perspectives* (pp. 113-140). Thousand Oaks, CA: Sage Publications.
- Taylor, B. C., & Trujillo, N. (2001). Qualitative research methods. In F. Jablin, & L. Putnam (Eds.), *The new handbook of organisational communication* (pp. 161-194). Thousand Oaks, CA: Sage Publications.
- Taylor, D. (2003). Fewer new drugs from the pharmaceutical industry. *British Medical Journal (International ed.), 326*(7386), 408-409.
- Te Ngaru Learning Systems. (2002). *Ariari o te oranga: Dual diagnosis, co-morbidity and co-existing disorders*. East Coast, New Zealand: Te Ngaru Learning systems.

- Tennant, M., O'Brien, M., & Saunders, J. (2008). *The history of the non-profit sector in New Zealand*. Wellington, New Zealand: Office for the Community and Voluntary Sector.
- Teplin, L. A. (1985). The criminality of the mentally ill: A dangerous misconception. *American Journal of Psychiatry*, *142*(5), 593-599.
- Thomas, P., Bracken, P., Cutler, P., Hayward, R., & May, R., & Yasmeeen, S. (2005). Challenging the globalisation of biomedical psychiatry. *Journal of Public Mental Health*, *4*(3), 23-32.
- Tilly, C. (1996). Invisible elbow. *Sociological Forum*, *11*(1996), 589–601.
- Tolbert, P. S., & Zucker, L. G. (1983). Institutional sources of change in the formal structure of organisations: The diffusion of civil service reform, 1880-1935. *Administrative Science Quarterly*, *28*(1), 22-39.
- Torrey, E. F. (1997). Taking issue: Psychiatric survivors and nonsurvivors. *Psychiatric Services*, *48*(5), 601-605.
- Torrey, E. F. (2011). Patients, clients, consumers, survivors et al: what's in a name? *Schizophrenia Bulletin*, *37*(3), 466-468.
- Torrey, W. C., Rapp, C., Van Tosh, L., McNabb, C., & Ralph, R. (2005). Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal*, *41*(1), 91-100.
- Torrey, W. C., & Wyzik, P. (2000). The recovery vision as a service improvement guide for community mental health centre providers. *Community Mental Health Journal*, *36*(2), 209-216.
- Townsend, E. (1998). *Good intentions overruled: A critique of empowerment in the routine organisations of mental health services*. Toronto, Canada: University of Toronto Press.
- Travis, M., Peters, E., Kerwin, R., & Institute of Psychiatry (2001). *Managing relapse in schizophrenia*. London, England: Science Press.
- Treacher, A., & Baruch, G. (1981). Towards a critical history of the psychiatric profession. In D. Ingleby (Ed.), *Critical psychiatry: The politics of mental health* (pp. 147-171). Harmondsworth, United Kingdom: Penguin.

- Treichler, P. A. (1987). Discourse and institutional authority: Medicine, education, and law. *Contemporary Sociology*, 16(5), 718-719.
- Trethewey, A. (1997). Resistance, identity and empowerment: A postmodern feminist analysis of clients in a human service organisation. *Communication Monographs*, 64(4), 281-301.
- Trethewey, A., & Ashcraft, K. L. (2004). Special issue introduction: Practicing disorganisation: The development of applied perspectives on living with tension. *Journal of Applied Communication Research*, 32(2), 81-88.
- Tuckett, A. G., (2005). Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse*, 19(1-2), 75-87.
- Tulloch, J., & Lupton, D. (1997). *Television, aids and risk: A cultural studies approach to health communication*. Sydney, Australia: Allen & Unwin.
- Turia, T. (1999, June 4). *ANGOA: Good Intentions*. Speech on presentation of the report Good Intentions: An assessment of the statement of Government intentions for an improved community-Government relationship. Parliament Buildings, Wellington, New Zealand. Retrieved from <http://www.beehive.govt.nz/speech/association-non-governmental-organisations-aotearoa>
- Turner, B. S. (Ed.). (1995). *Medical power and social knowledge* (2nd ed). Newbury Park, CA: Sage Publications.
- Turner D. (2002). Mapping the routes to recovery. *Mental Health Today*, July, 29-31.
- Turner, D., & Frak, D. (2001). *Wild geese: A report on a six month consultancy on the recovery approach*. Powys, Wales: Green Gauge Consultancy and National Schizophrenia Fellowship.
- Turner-Crowson, J., & Wallcraft, J. (2002). The recovery vision for mental health services and research: A British perspective. *Psychiatric Rehabilitation Journal*, 25(3), 245-254.
- U'Ren, R. (1997). Psychiatry and capitalism. *The Journal of Mind & Behaviour*, 18(1), 1-11.

- van der Haar, D., & Hosking, D. M. (2004). Evaluating appreciative inquiry: A relational constructionist perspective. *Human Relations, 57*(8), 1017-1036.
- van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse & society, 4*(2), 249-283.
- van Dijk, T. A. (2001). Critical discourse analysis. *The Handbook of Discourse Analysis, 18*, 352-371.
- van Hoof, F., van Weeghel, J., & Kroon, H. (2000). Community care: Exploring the priorities of clients, mental health professionals and community providers. *International Journal of Psychiatry, 46*(3), 208-219.
- Vaughan, G., & Hansen, C. (2004). 'Like minds, like mine': A New Zealand project to counter the stigma and discrimination associated with mental illness. *Australasian Psychiatry, 12*(2), 113-117.
- Venuti, L. (Ed.). (1992). *Rethinking translation: Discourse, subjectivity, ideology*. London, England: Taylor & Francis.
- Venuti, L. (2004). Retranslations: The creation of value. *Bucknell Review, 47*(1), 14.
- Wade, J. (1999). Mental health support work, New Zealand 1995–99. (Unpublished paper, Challenge Trust, Auckland New Zealand).
- Wadsworth, Y. (1998). What is participatory action research? *Action Research International* (Paper 2).
- Waghorn, G., Chant, D., & King, R. (2007). Classifying socially valued role functioning among community residents with psychiatric disorders. *American Journal of Psychiatric Rehabilitation, 10*(3), 185-221.
- Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behaviour, 30*(2), 220-239.
- Waitzkin, H. (1991). *The politics of medical encounters: How patients and doctors deal with social problems*. New Haven, CT: Yale University Press.

- Walker, J. (2009). Well-being: Do we need a new model for mental health service delivery? *Openmind*, 155(Jan\Feb), 6-9.
- Wallcraft, J. (2009, June). *Recovery: A double edged sword?* Paper presented at the Critical Psychiatry Network Conference. Norwich, United Kingdom. Retrieved from <http://www.mentalhealth.freeuk.com/Doubleedged.htm>
- Ward, N. (2009). Social exclusion, social identity and social work: Analysing social exclusion from a material discursive perspective. *Social Work Education*, 28(3), 237-252.
- Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2007). Connectedness and citizenship: Redefining social integration. *Psychiatric Services*, 58(4), 469-474.
- Ware N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2008). A theory of social integration as quality of life. *Psychiatric Services*, 59(1), 27-33.
- Warner, S. (2004). Radical politics from the Women's Liberation movement to Mad Pride. *Asylum: The Magazine for Democratic Psychiatry*, 14(2), 30-34.
- Warren, D. H. (1997). The hard end of community care. In C. Bell (Ed.), *Community issues in New Zealand* (pp. 35-50). Palmerston North, New Zealand: Dunmore Press.
- Warriner, R. (1997, July). *The Zen of mental health*. Paper presented at the World Congress of World Federation of Mental Health. Lahti, Finland.
- Warriner, R. (2001). Defining the future by responding to the shift to community based mental health services. *Incite: The Mental Health Journal of New Zealand*, 1, 14-26.
- Warriner, R. (2009). A consuming tension in mental health leadership. *Journal of Leadership in Public Services*, 5(3), 4- 9.
- Warriner, R. (2010). Clothing the emperor: What is now lacking in mental health services? *The International Journal of Leadership in Public Services*, 6(3 supplement), 73-83.

- Weaver, C. K. (2010). Carnavalesque activism as a public relations genre: A case study of the New Zealand group Mothers Against Genetic Engineering. *Public Relations Review*, 36(1), 35-41.
- Weber, M. (1946). Bureaucracy. In H. H. Gerth & C. W. Mills (Eds.), *From Max Weber: essays in sociology* (H. H. Gerth Trans.), (pp. 196-244). New York: Oxford University Press.
- Weeks, N. P. (1996). Reconciling scientific and religious discourse about madness during the age of reason: Lessons for today? *Journal of Psychiatric and Mental Health Nursing* 3(2), 95-101.
- Weick, A. (2000). Hidden voices. *Social Work*, 45(5), 395-402.
- Weick, A., Rapp, C. A., Sullivan, W. P., & Kisthardt, W. (1989). A strengths perspective for social work practices. *Social Work*, 34(4), 350-354.
- Weick K. (1995). *Sensemaking in organisations*. Thousand Oaks, CA: Sage Publications.
- Weick, K., Sutcliffe, K. M., & Obstfeld, D. (2005). Organising and the process of sensemaking. *Organisation Science*, 16(4), 409-421.
- Wenger, E. (1998). *Communities of practice: Learning, meaning and Identity*. Cambridge, United Kingdom: Cambridge University Press.
- Wheeler, A., Robinson, E., & Robinson, G. (2005). Admissions to acute psychiatric inpatient services in Auckland, New Zealand: A demographic and diagnostic review. *The New Zealand Medical Journal* 118(1226), 1752-1760.
- Whitaker, R. (2002). *Mad in America: Bad science, bad medicine and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Publishing.
- Whitaker, R. (2004). The case against antipsychotic drugs: A 50-year record of doing more harm than good. *Medical Hypotheses*, 62(1), 5-13.
- Whittle, A., & Mueller, F., (2012). Bankers in the dock: Moral storytelling in action. *Human Relations*, 65(1), 111-139

- Wicks, D. (2001). Institutionalised mindsets of invulnerability: Differentiated institutional fields and the antecedents of organisational crisis. *Organisation Studies*, 22(4), 659–692.
- Wilkinson, A., & Willmott, H. (1995). Introduction. In A. Wilkinson, & H. Willmott (Eds.), *Making quality critical: New perspectives on organisational change*, (pp. 1-32). London, England: Routledge.
- Wilson, C., Nairn, R., Coverdale, J., & Panapa, A. (1999). Mental illness depiction in prime time dramas: Identifying the discursive resources. *Australian & New Zealand Journal of Psychiatry*, 33(2), 232-239.
- Winter R. (1989). *Learning from experience: Principles and practice in action-research*. Philadelphia, PA: The Falmer Press.
- Wolfensberger, W. (1980). The definition of normalization: Update, problems, disagreements, and misunderstandings. In R. J. Flynn, & K. E. Nitsch (Eds.), *Normalisation, social integration and community services* (pp . 71-115). Baltimore, MD: University Park Press
- Wolfensberger, W. (1983). Social role valorisation: A proposed new term for the principle of normalization. *Mental Retardation*, 21(6), 234-239.
- Woodring, J., Foley, S. M., & Rada, G. S. (2006). Focus groups and methodological reflections. *Journal of Disability Policy Studies*, 16(4), 248-258.
- World Health Organisation. (2005). The Bangkok Charter for health promotion in a globalized world. *Health Promotion Journal of Australia*, 16(3), 168.
- World Schizophrenia Fellowship. (1998). *Families as partners in care: A document developed to launch a strategy for the implementation of programs of family education, training, and support*. Toronto, Canada: World Schizophrenia Fellowship.
- Yee, B., & Lapsley, H. (2004). *Journeys to equality*. Wellington, New Zealand: Mental Health Commission.
- Yip, K. (2000). The community care movement in mental health services: Implications for social work practice. *International Social Work*, 43(1), 33–48.

- Young, L. (2006). Providing recovery-based treatment to enhance quality of life. *Psychiatric Services, 57*(10), 1527-1528.
- Zald, M. N., & Berger, M. A. (1978). Social movements in organisations: Coup d'etat, insurgency, and mass movements. *American Journal of Sociology, 83*(4), 823-861.
- Zilber, T. B. (2002). Institutionalization as an interplay between actions, meanings, and actors: The case of a rape crisis centre in Israel. *Academy of Management Journal, 45*(1), 234-254.
- Zilber, T. B. (2006). The work of the symbolic in institutional processes: Translations of rational myths in Israeli high tech. *Academy of Management Journal, 49*(2), 281-303.
- Zoller, H. M. (2003). Working out: Managerialism in workplace health promotion. *Management Communication Quarterly, 17*(2), 171-205.
- Zoller, H. M. (2005). Health activism: Communication theory and action for social change. *Communication Theory, 15*(4), 341-364.
- Zoller, H. M. (2010). What are health organisations? Public health and organisational communication. *Management Communication Quarterly, 24*(3), 482-490.
- Zoller, H. M. (2011). Communicating women's health activism: A social justice agenda. *Women and Language, 33*(2), 73-79.
- Zoller, H. M. (2012). Communicating health: Political risk narratives in an environmental health campaign. *Journal of Applied Communication Research, 40*(1), 20-43.
- Zoller, H. M., & Dutta, M. J. (2008). Emerging agendas in health communication and the challenge of multiple perspectives. In H. M Zoller, & M. J. Dutta (Eds.), *Emerging perspectives in health communication: Meaning, culture, and power* (pp. 449-463). New York, NY: Routledge.
- Zoller, H., & Harter, L. M. (2010). Organising healing and health care resources. *Management Communication Quarterly, 24*(3), 446-448.

- Zoller, H., & Kline, K. (2008). Theoretical contributions of interpretive and critical research in health communication. *Communication Yearbook, 32*, 89-135.
- Zorn, T. E., Flanagin, A. J., & Shoham, M. D. (2011). Institutional and non-institutional influences on information and communication technology adoption and use among non-profit organisations. *Human Communication Research, 37*(1), 1-33.
- Zorn, T. E., Page, D. J., & Cheney, G. (2000). Nuts about change: Multiple perspectives on change-oriented communication in a public sector organisation. *Management Communication Quarterly, 13*(4), 515-566.
- Zorn, T. E., Roper, J., Broadfoot, K., & Kay Weaver, C. (2006). Focus groups as sites of influential interaction: Building communicative self-efficacy and effecting attitudinal change in discussing controversial topics. *Journal of Applied Communication Research, 34*(2), 115-140.
- Zuber-Skerritt, O., & Farquhar, M. (2002). Action learning, action research and process management (ALARPM): A personal history. *The Learning Organisation, 9*(3), 102–113.