

The Emergence of Recovery: A Genealogical Exploration of the
Forces of Power Shaping New Zealand's Mental Health
Services in the 21st Century

By

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Abstract

Recovery is a conceptual model that underpins New Zealand's mental health service delivery in the 21st century. This thesis explores how recovery emerged historically as an influential philosophy and how representations of recovery have changed to meet the needs of different groups. An inquiry, based on Foucault's genealogical method, investigates the historical and contemporary forces of power that have shaped the construction of mental illness, and the development of methods and techniques to support and manage persons labelled as mentally ill. The normalisation of knowledge developed during 19th century psychiatric practice provided a context for later critique and resistance from movements that highlighted the oppressive power of psychiatric discourse. Key to the critique were the antipsychiatry and service user movements, which provided the conditions for the possibility of the emergence of recovery as a dominant discourse. Since its emergence, recovery has moved through a number of representations as it was taken up by different groups. A significant shift in the 21st century has been the dominance of neo-liberal discourse based on consumerism, a rolling back of the state, and an emphasis on individual responsibility. The implications of this shift for users and providers of services and their effects on current representations of recovery conclude the inquiry.

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The lyrics from 'All the Madmen' (David Bowie, 1970) are taken from the album 'The Man Who Sold the World' copyright owned by Jones Tintoretto Entertainment Company LLC under exclusive licence to EMI Rec.

Contents

1. Abstract.....	2
2. Acknowledgements.....	3
3. Contents.....	4
4. Introduction.....	5
5. Chapter One: Two Perspectives of Recovery.....	11
6. Chapter Two: Genealogy – Power, Truth, and the Subject.....	19
7. Chapter Three: Normalising Knowledge.....	27
8. Chapter Four: Intellectual Critique and a Shift in Knowledge.....	37
9. Chapter Five: Personal Narrative, Collective Justice.....	43
10. Chapter Six: Political Ideology and the Promotion of Citizenship.....	53
11. Chapter Seven: A Panoptic Power.....	59
12. Chapter Eight: Techniques of Power and the Resilient Subject.....	71
13. Chapter Nine: Forces of Power and the Endurance of Knowledge.....	85
14. References.....	97

Introduction

And I'd rather play here

With all the madmen

For I'm quite content they're all as sane as me

David Bowie (1970), 'All the Madmen'

Critique does not consist in saying things aren't good the way they are. It consists in seeing on what type of assumptions, of familiar notions; of established unexamined ways of thinking the accepted practices are based

(Foucault 1954/2003, p.172).

This thesis investigates how recovery emerged to become a dominant discourse in New Zealand mental health service delivery, as an underlying philosophy and conceptual model. One way of answering this question is to explore how recovery has represented the needs of different groups through the inherent power associated with specific knowledge discourses. Therefore a Foucauldian approach to power relations has been used to investigate recovery in mental health practices as techniques of power.

To explore prevailing discourses and the power-knowledge relationship, Michel Foucault's (1977/1984a) genealogical framework has been used to identify potential conditions that led to various iterations of recovery. A history of the present is thus used to describe relations of power through normalisation of, and resistance to, knowledge about recovery from mental illness. Questioning historical conditions of emergence requires an understanding of what has come before, not in the sense of a linear evolution but rather by identifying the changing discursive conditions from which the current view arose. An exploration of a complete history of mental illness in the West is beyond the scope of this research and has been discussed in depth by many writers (see Foucault, 1961/2001; Porter, 2002; Shorter & Marshall, 1997, as examples). My focus is on the changing conditions of the late 20th century and early 21st century. I do however, briefly summarise the attitudes towards mental illness

that prevailed prior to the 20th century to provide a context for the later changes in the representation of madness, which supported the emergence of recovery as a conceptual model for the delivery of New Zealand mental health services in the 21st century.

My personal knowledge of recovery as an approach in mental health clinical practice was formed through the underlying philosophy and principles taught in an occupational therapy Bachelor's degree. My training in the United Kingdom, in the mid to late 1990s, introduced recovery as an approach that complemented the values of occupational therapy by promoting self-determinism and social and occupational inclusion to help persons with mental illness to achieve life goals. Since that time, both here and in the UK, there has been a greater emphasis on recovery principles in general mental health service delivery as a guiding philosophy that informs treatment methods. There have also been greater levels of accountability, requiring mental health services to provide environments conducive to recovery principles. I have witnessed a growing requirement for service users to engage in the recovery process through education and empowerment strategies, which is reflected in data collection and used for service targets.

The collection of data about service providers to support the recovery approach and document its impact on service users has increased in complexity and quantity over my years of clinical practice. Part of my current role as an occupational therapist is to evaluate the stages of recovery experienced by service users, to determine further interventions. Evaluation methods have been developed by managers to measure the quality of the service provided and ensure that each service user receives a recovery plan.

The language used to describe madness and mental illness has changed over time. Generally, I refer to 'persons with mental illness' in this thesis to describe persons who have been diagnosed by the medical profession with some form of mental illness, such as depression, schizophrenia or bipolar affective disorder. New Zealand mental health services currently represent persons with mental illness as

'service users' (Ministry of Mental Health, 2012); I will mainly use these two terms to describe a population also depicted through political history as 'lunatics', 'patients' and 'consumers'. I chose 'mental illness' as a general descriptive term as it is commonly used by media, service providers and service users. Other terms, such as, 'madness' and 'mental distress' are used in the context of representations of mental illness at particular times; for example, as a political strategy of reclamation by different groups.

I used the concept of problematisation to enable critical reflection (Bacchi, 2012) to challenge my own thinking about how I currently represent persons with mental illness from both a clinical perspective and one that incorporates recovery discourse. Problematisation as a term relates to how an experience can be shaped to be represented as a problem needing rectification (Miller & Rose, 1995). In this thesis problematisation supports an interrogation of disciplinary discourses, through social and political conditions, that have shifted recovery from a service user experience to a service provider approach.

The research included literature from the medical, clinical, auto-ethnographic, human rights, evidence-based practice, and political arenas, via journals, blogs, books and websites. Materials that implicated recovery discourse and potential conditions that led to its emergence were accessed alongside texts that represented recovery as events and practices (Hook, 2001), such as its use to highlight oppressive psychiatric treatment by the service user movement, and later, its role within clinical interventions.

The structure of the thesis is as follows:

Chapter one provides a brief synopsis of the two main perspectives of recovery depicted in this thesis: as a process experienced by persons with mental illness and an approach for the provision of services.

Chapter two provides an overview of the research methodology and a description of the key themes informing the thesis. The genealogical approach was chosen to

conduct a historical review of the present use of recovery to “enquire into processes, procedures, and techniques through which truth, knowledge and belief are produced” (Meadmore, Hatcher & McWilliam, 2000, p. 463). This thesis critiques recovery discourse and practice as techniques of power, which Foucault (1975/1984e) has depicted as mechanisms that create and maintain “a power relation independent of the persons who exercise it” (p. 201).

To look at the present use of the recovery approach by mainstream mental health services, a genealogy enables the analysis of a number of broad socio-political historical events. Genealogy can support the identification of specific techniques of power and governance that inform current mental health practice, examples being government strategy, best-practice research, and recovery planning.

Chapter three introduces historical information concerning the development of psychiatry and the normalisation of medical knowledge, detailing how historical representation of persons with mental illness created the possibility for critique. The chapter reflects on the knowledge and power inherent in medical discourse to provide a context for later movements that developed to resist psychiatry. A brief exploration of early psychiatry and the rise of diagnosis, which is a critical aspect of medical legitimisation, are included to enable analysis of the normalisation of current Western knowledge about mental illness. Material written by the early psychiatrists and those involved with the rise of diagnosis is included to highlight aspects of historical reasoning that endure in the present.

Chapter four introduces the anti-psychiatry movement of the mid-20th century, which led to the emergence of recovery discourse through advocacy and intellectual critique of the treatment of the mentally ill. The anti-psychiatry movement is explored to highlight the changing ways of thinking about mental illness in the mid-20th century, and the opportunities for shifts in knowledge and power for persons with mental illness.

Chapter five introduces the service user movement of the 1980s. The voice of the service user movement of the late 20th century is investigated as a major condition for the emergence of recovery as a mental health treatment approach. Material from

New Zealand is explored along with material from the United Kingdom (UK) and the United States of America (USA), as both of these countries influenced the development of the service user movement in New Zealand. Auto-ethnographic narratives from the late 20th century highlight an early perspective of recovery as personal experience that was transformed into a collective discourse for social justice.

Chapter six provides an analysis of a World Health Report from the 1950s. The report's inclusion, following an investigation of the service user movement in the 1980s, demonstrates the ways in which fluidity of discourse reflects political ideology. The report also challenges the assumption that the conditions of recovery originated solely from within the service user movement.

Chapter seven focuses on the historical documents, policies, strategies, plans and evidence-based research that informed the recovery approach in the latter half of the 20th century in New Zealand. Managerialism, consumerism and clinical governance are presented as techniques that influenced the internalisation of recovery discourse by the mental health workforce, regulating clinical behaviours and championing recovery as a conceptual model of practice.

Chapter eight provides an analysis of 21st century documents, policies, strategies and techniques that supported a shift of recovery discourse from a process to an approach. The chapter identifies how recovery was shaped to support the internalisation of health norms by service users and the general population to maintain wellness. Examples of tools that define and measure recovery are explored to illustrate the use of techniques of power and enduring historical knowledge relevant to the current positioning of persons with mental illness.

Chapter nine concludes the thesis with a closing critique of the forces that have shaped the emergence of recovery. Noting enduring historical knowledge represented in recovery discourse as contemporary knowledge, the chapter raises concerns about the neo-liberal influence on practices which can contribute as barriers to the acceptance and inclusion of persons with mental illness. Suggestions to support inclusion are offered.

Chapter 1: Two Perspectives of Recovery

This chapter provides a brief synopsis of two perspectives of recovery discourse that have been used by different groups since the 1970s. Historical influences and events that influenced recovery are briefly described to show how various groups assert knowledge as truth, which can then shape social practices to meet specific needs (Foucault, 1979/1984b; 1980/1984c). Recovery is introduced as a process via personal narratives, and as a service approach with reference to political ideology relevant to New Zealand healthcare since the 1980s. This chapter introduces the key themes that shifted recovery discourse towards the position of an underlying philosophy and conceptual model for New Zealand's mental health service provision.

The recovery approach in New Zealand is viewed as a fundamental philosophy in the present provision of mental health services. Recovery is generally defined in the two broad areas of personal recovery and clinical recovery (Jacobson & Greenley, 2001; Slade, Amering & Oades, 2008; Slade, Adams & O'Hagan, 2012). From the perspective of personal narrative, recovery represents the individual's experience through illness and the conditions that can lead to a satisfying life (Anthony, 1993; Shanks, Williams, Leamy, Bird, Le Boutillier, Slade, 2013). Signifying a journey rather than an outcome, the conditions of hope, autonomy, social inclusion, self-determinism, acceptance, and new meaning are prominent conditions of recovery that support quality of life for persons experiencing mental illness (Anthony, 1993; Deegan, 1988; Lipczynska, 2011). The journey does not necessarily end with wellness; rather, people achieve the life they want to live, with or without symptoms associated with mental illness (Mental Health Foundation of New Zealand, 2008).

As an approach for service delivery, recovery is a guiding principle for mental health policy and clinical practice, which aims to support persons experiencing mental illness to achieve quality of life with or without mental health symptoms (Anthony, 1993; Mental Health Commission, 1998; Roberts & Wolfson, 2004; Slade et al, 2014). From a clinical viewpoint, the approach has emerged from clinical research with a focus on symptom reduction, increased functioning, and independence

(Slade, Adams & O'Hagan, 2012). Recovery knowledge has been used in policy to promote an empowering environment that increases the participation of service users (Ministry of Health, 1997) and encourages healthy lifestyle behaviours (Ministry of Health, 2012).

Recovery in the context of this thesis is therefore seen as both a process – the steps/actions or interventions helpful to achieve personal wellness (Markowitz, 2001) – and an approach; how clinicians work to support the process of recovery by supporting self-determinism to regain a positive view of self (McCaffrey, Edwards, & Fannon, 2011). Defining two perspectives of recovery can support an understanding of the formation of a dominant discourse and the internalisation of that knowledge as truth (Foucault, 1980/1984c). Tension between the use of recovery as an approach and how it is experienced as a process is explored in later chapters to highlight the inherent power attached to discourses.

The language of recovery has circulated in New Zealand for almost thirty years. The 1980s witnessed recovery's emergence through the efforts of a small number of mental health service users influenced by contact with their peers in the United Kingdom (UK) and the United States of America (USA) (McClean, 1995; Spandler, 2006; O'Hagan, 2014). 'Psychiatric Survivors', a service user group formed in New Zealand in the mid-1980s, highlighted human rights abuse within the psychiatric hospital system, and developed a network of peer support for persons aggrieved by their treatment in mental health services. The service user movement, as it became known internationally and within New Zealand, was predominantly composed of persons experiencing mental illness who began to resist psychiatric discourse and challenge oppressive clinical practice by voicing personal experiences of illness and treatments in hospital (Crossley, 2002).

The first major perspective of recovery discourse, as defined in this thesis, emerged from the service user movement as a process. Uniquely personal accounts of recovery demonstrate the complexity of factors in the development of mental illness, and the individual and often arduous path towards wellness. Personal journeys are shared through websites, journal articles, blogs, books, conference presentations

and meetings. From auto-ethnographic narratives of illness and recovery, human experience as knowledge is foremost, with reference to potential illness precipitators in the form of childhood abuse or social ills, such as substance abuse and poverty (Deegan, 1987; Deegan 1988; Lampshire, 2009; Leete, 1989; Lovejoy, 1982).

Personal experience presented as truth asserted a position for persons with mental illness in psychiatric discourse, beyond the role of the passive patient. For persons with mental illness in the 1980s, recovery represented a right to be heard and included in the development and provision of services (O'Hagan, 2014). Through the narration of personal knowledge, individuals experiencing mental illness offered a new perspective on madness, as they termed it, and began to collectively oppose the way psychiatric discourse negatively positioned persons labelled as mentally ill (Crossley, 2002). The truth of recovery, from the service user perspective, was offered as an internal process that signified healing both from mental illness and from contact with mental health services (Chamberlin, 1990; Deegan, 1987).

Through the formation of a collective identity, the service user movement demanded greater control over the positioning of mental illness in society; for example, by identifying new language to better represent persons experiencing 'madness' (Rogers & Pilgrim, 1991).

Although each case is unique, some common experiences of illness are disclosed by service users, including a loss of personal identity compounded by medical diagnosis (Deegan, 1988; Lovejoy), stigmatisation and discrimination (Deegan, 2003; Kidd & Finlayson, 2010), and low self-esteem (Lampshire, 2009; Lovejoy, 1982). Personal narratives describing illness and engagement with mental health services are believed to support the process of recovering from illness (Grant, Leigh-Phippard & Short, 2015); critique and advocate for services relating to mental illness (Gregory & Thompson, 2013; O'Hagan, 2014, Ridgway, 2001); support and advise peers (Davidson, Bellamy, Guy & Miller, 2012); and to reduce stigmatisation (Corrigan, Kosyluk, & Rusch, 2013). Auto-ethnographic accounts of recovery describe the process of regaining control, autonomy, personal validity and reconnection with the self (Deegan, 1987, 1988; Lampshire, 2009; Leete, 1989; Lovejoy; O'Hagan, 2014).

The shift of recovery from a process to an approach occurred as a result of advocacy from both service users and service providers. Recovery, from a narrative

perspective, began to appear in international research in the 1990s and was used to advocate for the empowerment of service users through their inclusion in the planning and delivery of mental health services. In a seminal article published in 1993, Anthony's 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s' drew international attention to the conditions of recovery as observed in personal narratives. Anthony advocated for client-centred approaches in mental health service provision that aimed to shift the representation of service users from passive patients to empowered service users (Gawith & Abrams, 2006; Slade, Adams & O'Hagan, 2012; Watson, 2012). Anthony's (1993) often-cited definition of recovery is

a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (p. 15)

Anthony proposed that services organise a recovery environment, based on the rehabilitation model, incorporating "self-esteem, adjustment to disability, empowerment, and self-determination" (p.16) as principles to support positive outcomes of wellness. Recovery models that aimed to empower service users, for example the 'Tidal Model' (Barker, 2001) also aimed to emphasise the importance of interpersonal relationships between clinicians and persons with mental illness.

New Zealand witnessed the promotion of recovery, through the reorganisation of mental health services, from the end of the 20th century. Pertinent to the development of a New Zealand perspective of recovery was the inclusion of bicultural research focussed on Maori and non-Maori personal narratives (Lapsley, Nikora & Black, 2002) and awareness of culturally appropriate practices for Maori service users (Durie, 2001).

The Mental Health Commission, a committee composed of persons concerned with the delivery of mental health services, was established by the New Zealand government in response to challenges created by the changing environment of service delivery, now chiefly based in community settings rather than hospitals. The

commission was also established in reaction to severe system failures. A New Zealand report in 1988, compiled by faculties of law and psychiatry, detailed a number of major service delivery failures and the occurrence of human rights abuses in the provision of mental health services. Reflecting significant changes to clinical practice through community-based care, the 'Mason Report' as it became known (Mason, Ryan & Bennett, 1988) highlighted poor co-ordination between agencies, lack of resources, unclear lines of accountability and a lack of systematic collection of data concerning service users. The report noted blatant failures in systems of monitoring and communication that contributed to sentinel events including several suicides and a homicide.

In response to the Mason report (Mason, Ryan & Bennett, 1988) the Mental Health Commission was tasked with instituting the direction for community mental health services, which reflected growing international interest in recovery. Advocacy for recovery's inclusion in New Zealand policy emerged significantly in the 'Blueprint for Mental Health Services in New Zealand: How Things Need to Be' (Blueprint) (Mental Health Commission, 1998). In the document, stigmatisation and discrimination were exposed as major challenges preventing social inclusion of persons with mental illness, who had shifted from an institutional environment to community-based care during the late 1980s and early 1990s (Ministry of Health, 1994).

Prioritised by the commission, stigmatisation and discrimination from within the mental health workforce were noted as major barriers to recovery. Reacting to concerns regarding barriers to recovery, a survivor of mental health services, and founder of 'Psychiatric Survivors', Mary O'Hagan, developed a document that defined clinical recovery competencies, which aimed to shape the behaviours of service providers (Ministry of Health, 1997; O'Hagan, 2001). O'Hagan's document is explored in Chapter seven in the discussion of recovery as a panoptic form of power.

Recovery as a form of advocacy after the emergence of the service user movement challenged the idea of passive patients as recipients of services, and endorsed a greater role for persons with mental illness. Promotion of service users' involvement in service planning and delivery enabled the experience of mental illness to shape a more responsive and robust service that could better meet needs (O'Donnell et al,

1999). Advocacy aimed to enable persons with mental illness to realise their rights and contribute productively to society (Barnes & Shardlow, 1997).

The second major perspective of recovery discourse, defined within this thesis as an approach, emerged in New Zealand policy by the turn of the 21st century. New Zealand government policy, reflecting recovery discourse in the late 20th century, highlighted mental health services' responsibility to provide an environment conducive to the empowerment and participation of service users (Ministry of Health, 1994; Ministry of Health, 1997). By the beginning of the 21st century, recovery was authorised by the New Zealand government by its inclusion in policy. International research and internal concerns, such as health disparities in the Maori population (Ministry of Health, 2002), shaped a new perspective of recovery that had shifted focus from service providers to service users in regard to some of the responsibilities outlined in policy.

Policy does not take shape in response to national needs in isolation; rather it reflects events and attitudes from other countries and international organisations. The formulation of mental health national policies, strategic plans of action, and local procedures for implementation within New Zealand are broadly influenced by the World Health Organisation (WHO). Individual countries are requested to adapt global action plans to their specific socioeconomic and cultural-political needs (WHO, 2016). Definitions concerning mental health and illness are circulated by the WHO in policy documents and media releases, and are commonly incorporated in New Zealand's national policy (see Ministry of Health, 2006; Ministry of Health, 2012, as examples).

Current government perspectives on the inclusion of recovery in service provision guidelines can be found in 'Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017' (Ministry of Health, 2012). Recovery planning and illness prevention take precedence as being instrumental in improving the overall welfare of service users through education and the development of resiliency. "Health literacy" represents the need for individuals to stay healthy based on understanding information delivered by the health system (Minister of Health,

2016), through “better understanding how health fits into people’s lives and how it relates to their needs, interests and priorities” (p.16).

Recovery is currently noted as an evidence-based approach, informed by research, which can lead to positive outcomes for those who experience mental illness, especially when interventions are provided by clinicians who have a good understanding of the inherent values of recovery (Salyers et al, 2009; Williams et al, 2016). Through promotion and prevention strategies that embrace welfare, persons with a mental illness are encouraged to “lead their own recovery” within the broader health context that “all New Zealanders” are responsible for maintaining well-being (Ministry of Health, 2012, p.6). To support the evidence base of mental health practices, mechanisms that gather information on service user goals, types of services used, and outcomes are used as reporting tools (Ministry of Health, 2012).

Changes to the representation of mental illness and recovery in the last thirty years in New Zealand, which have occurred via the perspectives of personal narratives and policy, have not occurred in isolation from political ideology. Neo-liberalism has had a major influence on the delivery of mental health services in a number of countries, including New Zealand, since the 1980s (McGregor, 2001). A core assumption of neo-liberalism is the belief that individual interests advance the welfare of society through free market consumerism. Group interests and social conditions are considered less important (McGregor). Direct government intervention in social welfare is reduced through deregulation of laws and decentralisation of activities. Deregulation and decentralisation can be seen in the rise of nongovernment organisations providing services. Within neo-liberalism consumerism and managerialism, are techniques that aim to provide a choice of services to persons with mental illness and improve the quality of services, respectively (Wong, 2004). Another pertinent aspect of neo-liberalism for this research is its application as a governing mechanism for services by “organising and evaluating institutional performance” (McCarthy & Prudham, 2004, p. 276); for example, through the collection of performance indicators. Such mechanisms provide the opportunity for the use of surveillance techniques on specific populations; in this case, users and

providers of mental health services. Chapter seven explores these mechanisms in greater detail.

In the next chapter, the methodology of genealogy and key concepts that inform the inquiry are presented to show how recovery became an underlying conceptual model of practice in New Zealand mental health service provision. Genealogy enables a critique of current assumptions and ideas, normalised as knowledge that informs and directs current practices (Foucault, 1954/2003).

Chapter 2: Genealogy – Power, Truth, and the Subject

This chapter introduces the methodology known as genealogy, which was chosen to investigate how recovery is currently used as a dominant discourse influencing New Zealand mental health service provision. Genealogical inquiry is introduced with a brief exploration of the key themes of power, truth and subjectivity, developed by Foucault and fellow explorers.

Foucault's work, in general, has been described by Scott (2009) as an experimental process of "change, reconsideration, and recoiling back to move ahead – something like a process of continuously recreating himself and his work" (p.352). Theoretical debate concerning genealogical inquiry tends to highlight an element of unconventional experimentation due to a lack of predefined methodologies for conducting research (see Fadyl, Nicholls & McPherson, 2012; Hook, 2001; Meadmore, Hatcher & McWilliam, 2000; Nicholls, 2008; Tamboukou, 1999). However, a genealogy based on the writings of Michel Foucault remains concerned with the concepts of truth, power and the subject (Tamboukou) and the identification of potential conditions leading to forms of knowledge (Hook, 2001).

Influenced by the 19th century German philosopher Nietzsche, Foucault opposed the modernist perspective of viewing history as linear, progressive and objective. Burrell (1988) described that Nietzsche and Foucault emphasised the importance of practices over theory, acknowledging the position of subjectivity, "the claim of objectivity masks subjective motivations, high sounding stories hide the lowest of motives, accidents and lies lie behind the march of history" (p. 224). Genealogy has been referred to as a form of radical historicism by Bevir (2008) that arose in the 19th century as "denaturalizing critique...it denaturalizes beliefs, actions, and practices that others' conceive as in some way or other natural" (p.269), challenging the rationality of positivism. According to Crowley (2009), as an investigative method to analyse knowledge forms, genealogy aims to "illuminate the contingency of what we take for granted, to denaturalise what seems immutable, to destabilise seemingly natural categories as constructs and confines articulated by words and discourse

and to open up new possibilities for the future” (p. 3). Therefore, positivistic terms such as reliability and validity are not highly relevant in this thesis; from a postmodern epistemological position, the research aims to offer new possibilities regarding recovery through analysing discourse from the perspectives of service users and service providers. The information analysed in this thesis is broad, as a genealogy “depends on a vast accumulation of source material” (Foucault, 1984a, pp. 76-77). The personal narratives of service users and New Zealand policy concerning recovery were explored, as was the roles of psychiatry and the antipsychiatry movement to support context. As all the material for the thesis was sourced from publicly accessible sites; ethics approval to conduct the research was therefore not required.

Foucault’s work was chosen to guide this thesis as his philosophical forays questioned how people construct and understand meanings and consequently how they behave in the world. For example, he was particularly interested in, and opposed to, the notion of the autonomous individual who acts from self-direction. Rather, Foucault’s works highlighted how persons could be constructed as subjects through positive forms of power (Bevir, 1999). Positive power can be seen as productive activities that enable the formation of identity and develop the capacity and resources to live, which are shaped through culture, customs, institutions and individuals (Feder, 2011; McGushin, 2011). Positive forms of power differ from negative forms of power, which aim to repress activities and practices, and thereby oppress subjects (Heyes, 2011).

As an epistemology, Foucauldian genealogy does not set out to trace a meaningful development of knowledge through history; rather it challenges how truth and knowledge have been produced and legitimised (Stevenson & Cutcliffe, 2006; Tamboukou, 1999). Foucault (1977/1984a) argued that there are no essential meanings, only interpretations; therefore, knowledge can be viewed as a perspective. Inquiry into the past through genealogical research can enable a reappraisal of the legitimacy of present knowledge in terms of how that knowledge may have developed in the past (Meadmore, Hatcher & McWilliam, 2000), and how

historical reasoning may endure in the present (Folkers, 2016; Miró-Bonet, BoverBover, Moreno-Mulet, Miró-Bonet, & Zaforteza-Lallemand, 2014; Tone, 2005).

Genealogy can be useful when analysing mental health service provision as it challenges the underlying norms of knowledge that dominate clinical practice and can highlight political interests (Crowe, 2000; Moncrief, 2010; Tamboukou, 1999). As a methodology, genealogy has been used to critique the psychiatric perspective of normality by Crowe (2000) which places the fault of mental illness within an individual. In an analysis of civil commitment and the use of compulsory care in New Zealand, O'Brien (2014) identified the association of social factors with commitment suggestive that practices can serve the objectives of policy. The representation of persons with mental illness in New Zealand media was analysed by Coverdale, Nairn and Claasen (2001), noting how reporting stigmatised persons through associating illness with dangerousness and criminality, thereby highlighting the power of discourse.

Discourse is defined as a collection of spoken or written words about a subject and includes the practices associated with the ideas contained within them. Discourse analysis, from a philosophical perspective, has roots in post-structuralism which acknowledges the role of culture and social practices within the construction of knowledge and how specific concepts are used to promote certain knowledge as a truth. Discourse analysis thus takes the spoken word, texts, or imagery and explores the meanings and the knowledge contained within them. Analysis includes how the organisation and meaning of knowledge is contextualised and used by individuals or groups (Taylor, 2013).

In this thesis, the interest is in what discourses produce (Stevenson & Cutcliffe, 2006), and in questioning how discourses have been shaped and positioned by their authors (Hook, 2001), such as psychiatrists and service users. Foucault (1979/1984b), noted, "discourses are objects of appropriation" (p.108), suggesting that texts can be claimed and used according to the needs of the individual or group wishing to assert a certain position within knowledge. According to Foucault the production and operation of statements presented as truths act as forces of power that are both an effect of and an instrument of power. Foucault (1980/1984c) noted:

“Truth” is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements.

“Truth” is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extends it (p. 74).

Dominant discourses become discursive practice by way of the production and circulation of truths that influence how people perceive themselves and their world and therefore, how they act. Through discursive practice, individuals can be shaped so that their behaviours meet the needs of society. Shaping has been noted by Foucault as a way to produce “docile bodies” (1975/1984d, p. 179), such as learning a trade through competency-based training. Docile bodies can be constructed by positive forms of power that enable individuals to develop in ways that are useful and productive to society (Heyes, 2011).

Foucault viewed power as ever-present and pervasive in all forms of social interaction, moving away from the sovereign or top-down explanation of power associated with monarchy, law and domination (Lynch, 2011). He noted a shift from sovereign power towards a positive and productive technology, which aims to foster docile individuals, a technique defined by Foucault as disciplinary power. Discipline can be asserted from hierarchical subject positions; for example, medicine, that uses discursive practices to regulate behaviours. It can also be instituted from within the subject through the internalisation of rules and norms promoting conformity (Hoffman, 2011). As Heyes (2011) noted:

Disciplines create a subject who is self-monitoring, developmental, the object at the intersection of numerous vectors of management and coercion and, most of all, *useful*, productive (p. 162).

Disciplinary power produces the subject and the instruments that enable “progress towards an optimal end” (Hoffman, 2011, p. 30) through the organisation and observation of practices that are normalised in society.

The emergence of disciplinary power occurred with the development of the sciences.

Medicine, with its claims to science, became “regulated more in accordance with normality than with health” (Foucault, 1963/1989, p. 40) from the 19th century onwards. Governing populations through a focus on health norms, as opposed to the pre-19th century emphasis on illness, generated a new form of pastoral care for medicine that was more concerned with the body than the soul, as it had previously been (Hoffman, 2011). Foucault (1963/1989) noted that medicine must no longer be confined to a body of techniques for curing ill and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man (p. 39-40).

A new role for medicine had developed, concerned with promoting behaviours that endorsed health norms and which led to the objectification of individuals (Foucault, 1963/1989). Representing people as clinical cases of study and assigning them a role and position linked with illness enabled their objectification and thereby opportunities for social control (Hoffman, 2011). From the perspective of wellness promotion, labelling a person with a diagnosis of mental illness and becoming a case for study can legitimise specific practices, described as treatment, to create desired behaviour in otherwise troubling subjects. In this way, the recovery approach also aims to regulate the behaviours of persons with mental illness via specific interventions.

Recovery, as presented in modern New Zealand mental health service provision, is investigated here through research, policy and advocacy documentation to explore disciplinary power in current practices. For example, in the 21st century, recovery discourse, as an approach, guides the mental health workforce through clinical governance strategies, such as supervision. Recovery can also be used for monitoring services through performance indicators (Mental Health Commission, 1998; Shanks, Williams, Leamy, Bird, Le Boutillier, & Slade, 2013). Although the benefits of the recovery approach are clearly indicated in research (for example, see Salyers, Godfrey, McGuire, Gearhart, Rollins, & Boyle, 2009; Slade, 2010; Warner 2010; Williams, Deane, Oades, Crowe, Ciarrochi, & Andresen, 2016), there is an absence of inquiry that questions the use of recovery as a technique of power to govern populations, or bio-power as Foucault termed it.

In this thesis, governance is defined through disciplinary power, which occurs at an individual level, and bio-power, which occurs in relation to the management of populations. Foucault described disciplinary power on a macro level as bio-power; a method of population control through the normalisation of knowledge. He noted that power relations between individuals and populations are not generally controlled or developed by the state, but rather are influenced through the legitimisation of knowledge (Meadmore, Hatcher & McWilliam, 2000; Smart, 1986). Objectification on a macro level is possible as bio-power can access the body because it functions through norms rather than laws, because it is internalised by subjects rather than exercised from above through acts or threats of violence, and because it is dispersed throughout society rather than located in a single individual or government body (Taylor, 2011, p. 43).

Emphasis is on norms, produced as knowledge, which are regulated and circulated throughout society and specific groups to shape current practices and promote a healthy and productive society (Dreyfus & Rabinow, 1982). Foucault argued that the change from sovereign to bio-power had occurred alongside the development of industrial capitalism and the expansion of liberal ideology. He saw medical administration of the health of the population as a form of social control that would benefit a capitalist ideology focused on productivity (Foucault, 1975/1984e; Smart, 1986). In this thesis, bio-power is explored through New Zealand policy that represents norms and standards of health, including mental well-being, promoted to the general public.

The promotion of acceptable behaviours in the construction of subjects and coercion towards self-regulation were visually described in Foucault's description of the panopticon; a central structure containing hidden observers who at any given time can closely monitor the behaviours of their subjects (Feder, 2011; Roberts, 2005). A principal element of panoptic power is that the subjects being observed are also being trained to observe themselves; to comply with the expected behavioural norms to gain rewards, or avoid punishment. Panoptic power is distributed throughout structures by the normalisation of discursive practices (Feder, 2011) and which act as "methods of training that enable individuals to become integrated" (Foucault,

1984f, pp. 211-212) with the role of the institution. Clinical governance in the mental health area is explored in Chapter seven to demonstrate the discursive practices that regulate the mental health workforce.

Foucault (1975/1984f) described the establishment of a society increasingly disciplined by an authoritative gaze on subjects within its institutions. He noted that disciplinary techniques were exploited to have the maximum effect on populations, while being economically efficient and discrete to minimise resistance. An example of one such technique in mental health intervention, which is explored further in Chapter eight, is the 'Wellness Recovery Action Plan' (Copeland, 2002), which stipulates the process, actions and behaviours of the health professional and the service user. The process of encouraging self-monitoring behaviours through the formalised organisation of time and activities is designed to promote productive behaviours and create subjects who conform to social norms (Foucault, 1975/1984e; Heyes, 2011).

Labelling persons collectively, for example, as mentally ill, in conjunction with encouraging new behaviours, produces possibilities for new subjectivities (Foucault, 1975/1884e, Heyes, 2011). Subjectivity relates to the performance of the activities that make up the practices of the self, which are constrained or enabled by societal norms (Taylor, 2011b). Persons whose performance is constrained by a stigmatised identity, such as mental illness, can be dehumanised, as suggested by Butler, in an interview with Meijer and Prins (1988):

The abjection of certain kinds of bodies, their inadmissibility to codes of intelligibility, does make itself known in policy and politics, and to live as such a body in the world is to live in the shadowy regions of ontology (p. 227).

Constructing an intelligible subjectivity from a stigmatised identity can be problematic for those who are labelled with mental illness. An aim of this thesis is to create new possibilities concerning persons with a mental illness, which can support their inclusion and acceptance within society.

In the next chapter, the emergence and normalisation of mental illness through psychiatric discourse is briefly explored. The chapter identifies the construction of a stigmatised subject position through objectification and the early techniques used to shape behaviour and create new subjectivities. Psychiatric discourse, which was normalised as a form of truth, enabled later critique and resistance to its dominance and thus the emergence of recovery as the dominant conceptual model informing the provision of mental health services in 21st century New Zealand.

Chapter 3: Normalising Knowledge

Chapter three discusses the emergence and strengthening of psychiatric discourse, which has dominated social as well as clinical practices through the production, regulation and circulation of a medical perspective on madness. The chapter explores the emergence of psychiatric practice from the 18th century onwards and the rise of diagnosis as a technique of power within the discipline up to the present. Diagnosis legitimised practices that labelled and segregated persons for treatment and safety. The purpose of this exploratory chapter is to establish the normalisation of knowledge and discursive practices through multiple viewpoints, which eventually assisted the emergence of recovery in the 20th century through critique of psychiatry as an oppressive practice.

Examining the past through genealogical exploration can identify aspects of historical knowledge that endure in the present as truth (Folkers, 2016; Meadmore, Hatcher & McWilliam, 2000; Tone, 2005). The legitimacy of current knowledge concerning mental illness emerged during the period known as the Enlightenment in 18th and 19th century Europe. Science had superseded religious beliefs and myth, to develop new understandings of the world, and man's relationship with nature, based on an empirical view of knowledge (Cooper & Burrell, 1988). The organisation of scientific knowledge benefitted large scale industry and wealth production, enabling the development of specialised scientific fields (Horkheimer & Adorno, 2002) such as engineering and technology. Medicine and psychiatry as scientific fields also benefitted the growth of industry by contributing to a healthy workforce.

The Enlightenment was an "attitude" that defined and legitimised reason and knowledge, and defined man as an "autonomous subject" (Foucault, 1975/1984g, p.42). Reasoning and rationality represented a shift from religious discourse in understanding the world. This turn to science as a way to gain new information about the world supported the production of new subjectivities arising from "practices that act upon human beings and human conduct in specific domains of existence" (Miller & Rose, 1995, p. 428). The self as an autonomous subject was achieved through

productive roles that enhanced society (Burkitt, 2002; Miller & Rose, 1995). While productivity was equated with the autonomous subject who exemplified rationality, people categorised as mentally ill were viewed negatively, represented as non-productive and therefore, irrational (see Esquirol, 1845; Pinel, 1806).

Social reform, based on emerging scientific knowledge during this era, encompassed a specific interest in medicine that endorsed rationality and reasoning to define health and foster a productive society (Foucault, 1963/1989). Physicians in the 18th and 19th centuries understood reason and reasoning in scientific terms to “strictly imply numeration, reckoning, proportion” (Haslam, 1809, p. 12). Loss, error and subtraction of human characteristics and personality were described in treatises as intriguing and dreadful positions (see Barlow, 1845; Coventry, 1844; Esquirol, 1845; Haslam, 1809; Pinel 1806). For example, in his ‘Treatise on Insanity’, Pinel (1806) stated:

Of all the afflictions to which human nature is subject, the loss of reason is at once the most calamitous and interesting. Deprived of this faculty, by which man is principally distinguished from the beasts that perish, the human form is frequently the most remarkable attribute that he retains of his proud distinction (p. xv).

Esquirol (1845) labelled the insane as “the most stupid and vilest creature” (p.21). He noted the lunatic’s loss of morality through a lack of responsibility, which was characterised by distrust, fear, and failure to provide for future needs. Rationality and reasoning correlated with productivity as a social value; persons with mental illness, unable to participate in production, were thereby represented as irrational and subhuman. Reason was highly valued as it represented the move away from religious doctrines of a higher authority controlling man. Reason was seen as the capacity for critical thinking (Cooper & Burrell, 1988; Esquirol, 1845), and for those seen to lack the ability to reason, removal and seclusion from society was deemed beneficial to support a return to rational thinking (Pinel 1806).

Early psychiatry noted that the causes of madness included errors of routine, excessive imagination or meditation on subjects, and the influence and bearing of temper, human capacity and character (Esquirol, 1845; Pinel 1806). Influences

leading to madness included an uncultivated childhood, and “the consequences of neglected education, of unregulated passions, of vice, of misery” (Barlow, 1845, p. 301). Although environmental factors were considered, this was a period when madness was perceived to originate from within the subject (Foucault, 1961/2001).

Removing persons from society was legitimised by the medical profession, as vices and bad influences hindered the return to rationality (Pinel, 1806). By the 18th century, persons removed from society were commonly placed in institutions known as asylums. The asylum caused objectification of the lunatic through the medical construction of them as an object of study (Burrell, 1988). Once admitted, patients “become ‘cases’ who are measured, described, evaluated, examined and compared. Real lives are converted into written case notes” (p. 226). Pinel (1806) noted the role of observation by taking note of “whatever appeared deserving of my attention” (p.54) and proposed an initial categorisation of madness in 1774:

continuous during a large part of life or show long remissions, increase steadily, without interruption, or occur in regular or irregular attacks. This points to two kinds of madness: one continuous or chronic, the other intermittent or characterized by the most violent recurring symptoms (Weiner, 1992, p. 728).

Categorisation and observation were techniques used by early psychiatrists to support identification of appropriate interventions and to justify their use. Treatment reflected the pragmatism of the Enlightenment period, with emphasis on the restoration of intellect and rationality (Cooper & Burrell, 1988). Treatments to restore reason included interventions that impacted on mental symptomology such as mania, and physical indicators of ill health such as fever (Allen, 1850; Esquirol, 1845; Pinel, 1806).

Physicians of this era emphasised the benefits of moral treatment, a technique that sought to shape behaviour externally through rules and routines, and through the internalisation of rules and standards of behaviour by the patient. Pinel believed that moral treatment could be tailored to the needs of the person and thereby required knowledge of the causes of madness and the variety of symptoms and conditions.

He determined that the methods to regulate conduct in moral treatment differed depending on an individual's class and ethnicity. Allen (1850) noted that

[t]he proper treatment of insanity from its onset, is to bring its subjects under the discipline of those public institutions which combine in their arrangement the various appliances necessary in enforcing the best moral and medical regimen, with the least coercion or unkindness to the patient (p. 267).

Pinel (1806) wrote of the benefits of coercion, a system of reward and punishment, stating that "a state of dependence and constraint may greatly accelerate the cure of the madman who is elated to improprieties of behaviour, by imaginary consequence, or by the recollection of dignities and power once possessed" (p.187). Recovery from mental illness, within the Enlightenment period, was seen as a return to reason, the regaining of intellect, and the ability to think critically once more (Allen 1850; Esquirol, 1845; Pinel, 1806). For those patients where coercion and medical treatments failed to fully restore reason, or where it was felt that external factors would clearly lead to relapse, indefinite confinement was used.

Order, classification, and categorisation – known as diagnosis – continued through the 20th century as one of the key ways to support the legitimisation of psychiatry as a science. Concern about psychiatry's poor standing as a profession in relation to research was noted by German physician Emil Kraepelin in 1887 to be due to the lack of a common foundation "on even its most fundamental principles" (Engstrom & Weber, 2005, p. 350), including a collective scientific language. Legitimacy of psychiatry through its union with medicine was notably enhanced by Kraepelin through neuropathology (autopsy and biopsy). Kraepelin successfully endeavoured to increase the scientific validity of research concerning mental disorders through an empirical approach (Jablensky, 2007). He aspired to bring an element of order to the differing presentations of mental illness by emphasising the inter-relating factors in the course of the disease process.

Kraepelin noted the dominance of neuropathology as scientific discourse through alliance with medicine, but he also wrote of the emergence of psychology within the mental phenomena of illness. Psychological knowledge was validated by Kraepelin

as it “has become a natural science like any other, and therefore it has a legitimate right to expect that its achievements receive the same respect and recognition as other auxiliary disciplines that we use to construct our scientific house” (cited in, Engstrom & Weber p. 356).

The legitimisation of psychiatry as a science developed further in the 19th century through the work of a number of prominent physicians (see Kendler, 2009) who proposed different perspectives for the classification of mental illness. Diagnosis as a term had become more prominent and complex in its descriptions of mental illness by the middle of the 20th century.

Diagnosis is a concept used to identify and describe a disease for the purpose of treatment. In the medical field, a diagnosis assumes that there is a universal, underlying biological defect or malfunction causing symptoms, which are then identified as the disease (Moncrieff, 2010). Diagnosis is a method of communication between those in the health profession and in a wider sense, in society, that can identify non-healthy from healthy, illness from wellness, and abnormality from normality (Crowe, 2006).

Diagnosis can situate persons represented as mentally ill in a manner that serves dominant society (Taylor, 2011). For example, diagnosis can be seen as a political device, a technique of power that allows social practices to care for, or control, persons presenting with behaviours that are perceived by government as deviant. Deviance can be described as a malfunction, fault or failure in relation to the criteria of norms based on social and political judgements (Roach Anleu, 2006) and be medicalised by representation as illness. Once diagnosed with a mental illness, people can access certain resources in the form of treatments, which range from pharmaceuticals to hospitalisation. Treatment may be voluntary for the person who accepts the diagnosis or compulsory for those who do not, or are deemed to be a danger to themselves or others. The aim is to correct the fault or failure and resume a recovered identity as mentally well. Moncrieff (2010) argues that by representing deviant behaviour as illness that requires treatment, social control is masked as treatment.

Diagnosis has developed a prominent role in psychiatry as a classification system via the Diagnostic and Statistical Manuals (DSMs) that guide the psychiatrist in the assessment and treatment of mental disorders. The DSM of mental disorders, now in its fifth version, is the most influential and imposing discourse to have shaped Western psychiatric practice, through global distribution, in the last few decades. As a discourse it appears natural and objective to civil society, through the assertion that the knowledge contained in the manuals represents the reality or the truth concerning madness, when in fact it is but one concept or paradigm (Alarcon et al, 2009; Crowe, 2006, Mayes and Horwitz, 2005; Spitzer, 2001; Wilson 1993).

Initially developed in the 1950s in the USA, the first two versions of the manual (DSM-I and DSM-II) mirrored the psychodynamic paradigm, which assumed that unconscious developmental experiences correlated with behavioural and emotional manifestations in later life (Neumann & Hirschhorn, 1999). Brief descriptions of mental disorders were collated in the DSM for statistical record-keeping, with little influence on educational and clinical practices (Spitzer, 2001).

Diagnosis gained prominence from the 1960s, culminating in the 1980s in the DSM-III. Its success related to the claim that the information in the manual was scientific and that psychiatric practice was the legitimate way to treat symptoms, as problems were medical in nature (Mayes and Horwitz, 2005; Moncrieff, 2010; Wilson, 1993).

Bentall (2006) summarised the anticipation of the period succinctly: “In those heady times, it was often forgotten that, far from being designed on the basis of objective scientific research, the criteria listed in the DSM were no more than psychiatric folklore institutionalised by committee” (p. 222). A core value for the DSM-III that heralded a change to the medical model in psychiatry was that in order to effectively treat patients with mental disorders, an accurate diagnosis was required. Only psychiatric diagnosis could support reliability and validity of treatments, even though the empirical research data to back up these claims was absent (Bentall).

The release of the DSM-III in the 1980s coincided with the strengthening of neoliberal ideology. Neo-liberalism sought to deregulate government responsibility by representing psychiatric and pharmaceutical knowledge as the most reliable cure for madness, strengthening psychiatric discourse (Burchell, 1993). Neo-liberalism

and the pharma-psychiatric alliance encouraged the representation of persons with mental illness as consumers of services. The ever-expanding prominence of medications represented a dominant route to achieving normalcy and health and supported the shift of treatments from institutionalised settings into the community (Gronfein, 1985; Scull, 1981). Neo-liberal ideology and emphasis on medication as treatment is argued by Esposito and Perez (2014) to conceal and suppress social causes of illness and distress, which further situates the problem of illness with the individual.

The publication of the DSM-IV in the 1990s aimed to minimise what were seen as uninformed elements in the DSM-III and its revised edition, through the inclusion of greater rationales for the evidence base. An aim of the manual was to create consensual understanding of diagnostic knowledge when read by scholars from a range of theoretical backgrounds, thus asserting psychiatric knowledge in other disciplines of health and science (Francis, Widiger & Pincus, 1989).

Emphasis on diagnostic labels as objective truth shaped the way persons with mental illness were externally represented (Crowe, 2000). Diagnostic labelling was also internalised by patients, though it was eventually critiqued by the service user movement as leading to the loss of a sense of self (Chamberlin, 1990; Deegan, 1987).

Bentall (2006) noted the clinical utility of labelling through diagnosis as questionable, especially in the context of a conceptual lack of clarity. For example, various perspectives from inside and outside the field of psychiatry have tried to define mental disorder as something real, or something constructed heuristically or socially, or simply as a function for treatment (Esposito & Perez, 2014; Frances & Widiger, 2012; Wilson, 1993). Frances and Widiger (2012) noted that in a review of definitions for the DSM-IV, none were deemed particularly useful as “the concept of mental disorder is so amorphous, protean, and heterogeneous that it inherently defies definition – creating a hole at the center of psychiatric classification” (p.111).

Diagnosis as discursive practice can also occur outside the realm of psychiatry; for example, in the legal arena. Diagnosis is used for the compulsory assessment and

treatment of persons with mental illness. New Zealand's process for formally treating persons with a mental illness in the community is currently detailed in 'The Mental Health (Compulsory Assessment and Treatment) Act 1992' (MHA, 1992) (Parliamentary Council of New Zealand, 1992). The definition of mental disorder is based on categorisation as to whether a specific behaviour or symptom falls within a specific category, and aims to distinguish disorders from non-disorders (Wakefield, 1992). Current New Zealand understanding of the term mental disorder in all its complexity has been influenced by the Australian psychiatrist Aubrey Lewis (Dawson, 2013). Lewis (1953) suggested that propositions have meaning due to both the complexity of the idea and its attachment history, requiring an acceptance of assumptions that can define and separate illness and health.

According to Lewis (1953) the distinction between mental health and mental illness involved "qualitatively altered function of some part of the total, by disturbance of thinking, as example, or disturbance of perception" (p. 113). Taking the human body as an organism, Lewis stated that internal equilibrium to maintain health is achieved through adjustment and adaption to stimuli. However, judgements as to what is adaptive or maladaptive are value-based; for example, social disapproval or perceived non-conformity. Illness, Lewis stated, was determined when nonconformity occurred alongside psychological dysfunction, examples being thinking, perception and memory.

Determining mental disorder in the legal sense is not wholly based on whether or not a person's mental state is believed to be normal in comparison to social norms during assessment. In the context of a fluctuating or intermittent abnormality or disorder (as noted in the MHA, 1992 definition), mental disorder can be determined if a person has previously experienced or is predicted to experience the disorder again in the future. However, for the purposes of the MHA, 1992 (Parliamentary Council of New Zealand, 1992), the disordered person must also meet the criteria of posing serious danger or marked incapacity for self-care.

Once a person is determined as mentally disordered and a risk to self or others and is believed by the medical profession to lack insight, or refuses treatment, an order for compulsory treatment may be applied for in the courts. Originally introduced in the United States of America (USA) in the 1970s, compulsory treatment became a

practice in mental health service provision in Canada, Australia and New Zealand within the following two decades. 'Compulsory Treatment Orders' (CTOs) emerged during the process of deinstitutionalisation (O'Brien, McKenna & Kydd, 2009). CTOs have been described by Campbell, Brophy, Healy and O'Brien (2006) as a tool for mental health service users who lack capacity and are at risk to others but who may be able to live in the community under controlled circumstances. Some mental health laws therefore compel service users to live in certain settings, attend clinics or centres for care and treatment, and accept medication (p.1102).

The development of the CTO was in conjunction with the emergence of a community care policy (O'Brien, McKenna & Kydd, 2009) to manage dangerous behaviours in the community and avoid the need for hospitalisation (Campbell et al., 2006; O'Brien, 2010; O'Brien, Kydd & Frampton, 2012). Dangerousness perceived as risk is normally associated with violence to others or self, including suicide. The depiction of mentally ill persons as dangerous is often supported by media.

Focusing on worst-case scenarios, the media compounds the perspective that persons with mental illness are dangerous. From a study of 600 New Zealand newspaper articles over a period of one month in 1997, Coverdale, Nairn, and Claasen (2002) noted a dominance of negative stereotyping that correlated mental illness with criminal activity and dangerousness. While this research was conducted some time ago, such representations have persisted through an ever-widening array of social media, continuing to create barriers to social inclusion.

The media predominately reports on significant scenarios of violence arising from mental illness. Sentinel events involving homicide situate mental illness negatively through the "transformation of fear into a cultural perspective through which society makes sense of itself" (Furedi, 2005, p. 131). Portrayal of persons with mental illness as dangerous, in contemporary New Zealand, promotes a climate of fear through the use of specific terminology, for example, "insane killers living in the community" (Mussen, 2016, para. 8); and "at the time of his rampage" (Tait, 2016, para. 13). From Furedi's (2005) perspective, language that equates specific subjects with dangerousness can create fear in general populations, which is experienced through

a sense of powerlessness and vulnerability to the dangerous subject. Furedi (2008) noted how vulnerability can be ascribed to subjects by government and normalised, “[t]hrough vulnerability-led policies the sense of powerlessness is cultivated as part of the normal state of being” (p. 654). He suggested that vulnerability was framed by government to establish a mood of helplessness, which could be counteracted by policy that aimed to increase the resilience of its populations against adversity. By defining resilience through its absence in subjects, policy could then address this deficiency “to institutionalize a top-down professional approach that will leave little room for local initiative” (Furedi, 2008, p. 658).

Multiple viewpoints of mental illness, including lived experience, policy directives, media and neuroscience (Middleton, 2008) have emerged since the Enlightenment period and the early categorisation of symptoms and behaviours into disorders. Diagnosis has developed as a dominant tool providing a framework and authority for the practice of psychiatry (Jutel, 2009), which continues to dominate the provision of government-led mental health services. Nonetheless, the discourse of psychiatry and the tool of diagnosis have faced strong resistance, for example, from the anti-psychiatry movement’s intellectual critique during the 1960s. Anti-psychiatry is explored in the following chapter to investigate how resistance to psychiatric discourse supported the emergence of a new perspective of mental illness that validated the experience of madness as a legitimate discourse.

Chapter 4: Intellectual Critique and a Shift in Knowledge

In this chapter, the anti-psychiatry movement is identified as a condition of possibility that led to the emergence of recovery through intellectual resistance to psychiatric discourse. In the previous chapter, psychiatric discourse was presented as knowledge that provides a tool and authority for clinical practice (Jutel, 2009), which has been normalised in Western societies. Use of knowledge to meet the needs of one group in society can lead to resistance in the form of opposing discourse from other groups. Anti-psychiatry is a broad movement that critiqued psychiatric discourse from within the profession between the end of the 1950s and the beginning of the 1970s.

Anti-psychiatry emerged across Europe and the USA in response to concerns that madness, a favoured term used by marginalised groups, was becoming increasingly medicalised. Medicalisation has been described by Conrad (1992) as a sociocultural practice which “consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it” (p.211). The movement, a “revolt from above” (Crossley, 2002, p. 142), was led by a number of psychiatrists and sociologists including Thomas Szasz, Erving Goffman, R.D. Laing and Franco Basaglia, as well as Michel Foucault. Despite the term anti-psychiatry being disputed in relation to Basaglia (Foot, 2015), Szasz (1994) and Foucault (Bishop, 2009), for the purpose of this thesis, persons who intellectually critiqued psychiatric practices during this era are referred to as the anti-psychiatry movement.

Individually and collectively, the movement emphasised psychiatry’s power as an oppressive form of governance in society that used the concept of mental illness to stigmatise behaviour deviating from social norms. Highly critical of the asylums, the movement drew attention to human rights abuse, questioning discursive practices relating to the confinement and treatment of persons labelled as mentally ill (Berlim, Fleck & Shorter, 2003, Crossley, 2002; Crossley, 1998; Farber, 1993). Asylums were criticised as places that institutionalised roles and behaviours through the existence

and routines of asylum life (Berlim, Fleck & Shorter; Brunton, 2005; Papeschi, 1985). Individually, the members of the anti-psychiatry movement highlighted how medicalisation supported the objectification (Laing, 1964), social control (Foucault, 1963/1989; Goffman, 1969), and stigmatisation (Goffman 1968) of persons labelled as having a mental illness.

Defining an individual as a subject through labelling dates back to the 18th century (Burrell, 1988) and centres on a person's behaviour with little regard to the person's experience (Laing, 1964). The development of psychiatric diagnosis from within medical discourse assumed that an internal defect causing symptoms required categorisation to enable treatment, often in segregation from society; positioning the individual as a case (Moncrieff, 2010). According to Goffman (1959), diagnosis and hospitalisation supported objectification, creating the possibility for stigmatisation.

The anti-psychiatry movement drew attention to the objectification of persons diagnosed as mentally ill through the way they were positioned and assigned roles within psychiatric discourse (Berlim, Fleck & Shorter, 2003; Goffman, 1959; Szasz, 1994). Objectification occurs through the initial examination, documentation and definition of the patient as a case or a diagnosis (Hoffman, 2011). Defined as a case, a person with mental illness could experience a humiliating process through the loss of normal roles, self-identify and functioning, especially on entering an asylum (Goffman, 1969).

The admission procedures at the asylum accomplished objectification through the elimination of physical, social and psychological attributes of the self. This occurred

by the case-history construction that is placed on the patient's past life, this having the effect of demonstrating that all along he had been becoming sick, that he finally became very sick, and that if he had not been hospitalized much worse things would have happened to him (Goffman, p.131).

Objectification through diagnosis occurred in relation to a person's behaviour rather than their experience, as experience was inferred by mainstream psychiatry as being invalid within the label of abnormality (Laing, 1964). In resistance to medical

discourse, Laing proposed that abnormal behaviours, labelled as mental illness for a person with psychosis, could rather be viewed as a strategy to manage psychologically unbearable situations. Questioning perceptions of sanity, Laing proposed attention to the individual's experience:

If we naively regard our norm of sanity as the measure of insanity, then we are led to precisely the point of view that is currently held about schizophrenia. But if we see our sanity as already a state of extreme alienation, then we will be less ready to suppose that the schizophrenic is more alienated than we are from the totality of reality (p.190).

His view was shared by Basaglia, who believed that mental illness was caused by social adversity and therefore could not be situated within the body (Berlim, Fleck & Shorter, 2003; McLaughlin, 2003). Basaglia argued that “the patient mainly suffers from being compelled to choose to live in an aproblematic and adialectic way, because the contradictions and the violence of our reality can be often unbearable” (cited in Papeschi, 1985, p. 252).

Objectification through diagnosis was challenged by the movement from the perspective that the power of psychiatry lived within the metaphoric use of language. Szasz (1960) noted that mental illness “is not literally a ‘thing’—or physical object—and hence it can ‘exist’ only in the same sort of way in which other theoretical concepts exist” (p. 113). The construction of illness by representing a disease as a diagnosis was questionable, as the names of diseases could vary across time and cultures (Szasz, 1994). Diagnosis could be attained through a selective focus on negative aspects of an individual's past, highlighting bad judgements, inappropriate behaviours and factors that confirmed sickness and the need for confinement (Farber, 1993; Goffman, 1959).

Concerned by political aspects of diagnosis, Goffman (1969) indicated that unlike medical disorders that deviate from the norm without social or moral connotations, behaviours linked with mental illness were viewed as deviating from “social norms, that is, an infraction of social rules and social expectations” (p362). As a tool, social control exerted through psychiatry was believed by the movement to meet dominant social values reinforcing a productive and compliant society (Papeschi, 1985), by

regulating non-conformist and anti-social behaviours (Mayes & Horwitz, 2005). A notable example of psychiatry constructing deviancy from social norms as mental illness was the inclusion of homosexuality in the Diagnostic and Statistical Manual (DSM) prior to its third incarnation. The removal of homosexuality from the DSM only occurred due to public resistance rather than reconsideration from within the discipline of psychiatry (Mayes & Horwitz, 2005; Spitzer, 1981). To support the shaping of society, diagnosis naturalised social norms through the internalisation of rules.

Externally imposed rules that are internalised to self-manage behaviours become naturalised and are consequently made invisible through the constitution of the self (Foucault, 1963/1989; Roach Anleu, 2006). Internalisation of rules can reduce resistance and erode a sense of self subjectivity, creating space for the psychiatric perspective of the self (Goffman, 1959; Hacking, 2004). For example, Goffman (1959) argued that the physical locality of hospitalised individuals framed a self-constructed subjectivity based on illness, which was reinforced by staff who noted that his past has been a failure, that the cause of this had been within himself, that his attitude to life is wrong, and that if he wants to be a person he will have to change his way of dealing with people and his conceptions of himself...requiring him to practice taking this psychiatric view of himself (p. 133).

The internalisation of negative stereotyping from healthcare staff as a form of prejudice can result in reduced self-esteem and self-efficacy; conditions noted by Corrigan and Rao (2012) to precede self-stigma. Stigma was noted by the antipsychiatry movement as a consequence arising from objectification and labelling through diagnosis (Foucault, 1963/1989; Goffman, 1959, Goffman, 1969; Laing, 1964). Self-labelling can occur initially as persons attempt to make sense of distressing experiences, such as hallucinations, within the dominant discourse of psychiatry (Krauss, 1968). Formal diagnosis and objectification by a psychiatrist can lead to stigmatisation by others through prejudice, attitudes and discrimination, often resulting in rejection and exclusion (Thornicroft, Rose, Kassam & Sartorius, 2007). The consequences of stigmatisation potentially result in reduced life opportunities, disempowerment, and a devalued position in society (Harrison & Gill, 2010), which can strengthen self-stigmatisation.

The anti-psychiatry critique of objectification as a human rights abuse highlighted the lack of power attached to the role of the patient and the ensuing stigmatisation. From an intellectual standpoint the experience of mental illness, as opposed to the behavioural consequences, was highlighted by the movement to draw attention to social adversities often faced by those persons incarcerated in asylums (Goffman, 1959; Papeschi, 1985). The movement noted how psychiatric practices led to a process of dehumanisation, which could be used to corroborate the existence of illness as an internal fault (Goffman, 1969).

Although critique was not supported by many in the psychiatric profession, the movement supported the emergence of new perspectives on madness and encouraged the possibility of new conditions for practice. Szasz is known for opposing state-sanctioned interference in the behaviours and choices of individuals, citing freedom from the motivations of others as more valuable than health itself (Moncrieff, 2014). His views are believed to have gained the support of persons labelled as mentally ill, and generated a connection with activists, liberal professionals and critics of psychiatry (Berlim, Fleck & Shorter, 2003). Foucault's (1977/1984a) analysis of practices through history was seen as an unmasking of modern power systems. He argued that disciplinary power turned individuals into certain types of subjects through behavioural training; for example, in how to live in response to medical knowledge.

Behavioural training as a form of social control in asylums was noted as an abuse of human rights by Basaglia (Papeschi, 1985) and Goffman (1959). Goffman's argument that asylums were anti-therapeutic (as the least form of harm) was believed to have supported the widespread closure of costly institutions across the USA. Changes proposed by the movement represented a push towards the deregulation of services, an attitude that reflected neo-liberal ideology.

For example, Basaglia's reorganisation of mental health service provision in Italy influenced the closure of asylums in Europe as well as in Ireland, Finland, Australia and New Zealand (Rissmiller & Rissmiller, 2006). Basaglia attempted to ensure that the community services replacing the asylums did not replicate the asylums ethos, and that patients living in the community with the support of clinicians could tackle

the social causes of exclusion. His ideas encouraged health professionals to work increasingly closely with community organisations, political parties, unions and family member groups. An attitude of cooperation also promoted the involvement of ex-patients and those receiving treatment, supporting the development of consumer groups (Lovell, 1986).

During the 1960s and 70s, Laing became popular with ex-patients via his work in a variety of media including not only traditional lectures and papers, but also theatre, film, radio and television. His influence was noticeable in educational and political fields, with admiration and scorn from his colleagues, for example, for using and proposing the hallucinogenic drug LSD as a treatment (Crossley, 1998). Those who supported Laing and his colleagues attempted to imitate some less traditional ideas in the establishment of therapeutic communities, notably Laing's Kingsley Hall in London, which was as much a venue for counter-culture events as a place of treatment (Crossley, 2006). Laing proposed the formation of centres of care, to which persons with mental illness could come and go as a strategy dependent on their situation, forming links with ex-patients (Laing, 1964). He is credited with being a key figure in awakening the service user movement through a discourse that acknowledged patient experiences by creating a space for their voices to be heard (Crossley, 1998).

Anti-psychiatry promoted expression of the experience of mental illness by including the voices of persons labelled as mentally ill in research, and through media broadcasts to the wider community. In the next chapter, psychiatric critique from the voices of persons experiencing mental health services is introduced to note how personal experience became collective resistance, enabling the emergence of recovery as a technique of power.

Chapter 5: Personal Narrative, Collective Justice

In this chapter, the service user movement is introduced as a critique of the oppressive power of psychiatry that arose from within the field. Material from movements in the UK and USA is included as both these countries influenced the arrival of New Zealand's service user movement in the 1980s. This chapter investigates how persons with mental illness produced a new discourse, resisting a medicalised subjectivity that positioned them as irrational and irresponsible. Challenging the power of psychiatric discourse by reframing difficult personal experiences as rational responses to adversity, the service user movement shifted recovery from an individual journey towards "discourses of active citizenship and social justice" (Adame & Knudson, 2007, p. 161). Through personal narrative, the movement constructed a new perspective on recovery from mental illness, which was later used as a conceptual model, influencing New Zealand's delivery of mental health services.

The service user movement did not evolve uncritically from the ideology of antipsychiatry. People who had experienced mental illness and asylum life were disenchanted by the philosophical intellectualisation of mental illness and the lack of attention to their perspectives in politics and the media (Berlim, Fleck & Shorter, 2003; Chamberlin, 1990; Crossley, 1998; 2002). However, service user discourse supported anti-psychiatry ideology that had criticised the oppressive power wielded by psychiatry. The medicalisation of madness, which was used as a political tool for social control (Foucault, 1963/1989; Goffman, 1969), created the initial interest in the movement in the 1970s, as documented by Jackson (2008):

At that time, the byword for getting involved in user groups was the perception of psychiatry as a form of social control. There was very little emphasis on the kinds of involvement available to service users today - consultations about the nuts and bolts of running services. The groups were much more political. The last thing we would have thought about was joining a committee to discuss community care. (para. 4)

The view of anti-psychiatry that illness was a strategy to cope with social adversity (Laing, 1964; McLaughlin, 2003; Papeschi, 1985) was also revealed in the accounts of persons with mental illness, such as Debra Lampshire (2009, p. 184), “I consider my madness a reasonable and rational response to situations and events that I was ill-equipped to deal with”, and Joan Houghton (1982, p. 548), “[t]he difficulty is a function of the fact that my reality is your reality—that I, like you, struggle to cope and survive each day in a turbulent world”. The stigmatising of persons with mental illness by objectification was exposed, for example, by Esso Leete (1989, p. 199), “to be a patient or even ex-client is to be discounted. Your label is a reality that never leaves you; it gradually shapes an identity that is hard to shed”. And as Patricia Deegan (1987, p. 2) noted, “[w]e are here to witness that people who have been diagnosed with a mental illness are not things, are not objects to be acted on”. Deegan particularly noted how psychiatry dehumanised people through the process of diagnosis and labelling, which led to a loss of sense of self:

If we insist that a person learn to say, “I am a schizophrenic”, then in essence we are insisting that the person equate there (sic) personhood with illness. Through such a dehumanizing reduction the disease takes on what is called a “master status” in terms of identity (p. 12)

Groups resisting psychiatric discourse are not a new phenomenon; the ‘Alleged Lunatic’s Friend Society’ in mid-nineteenth century UK is one noted ‘consumer-survivor’ movement (Frese & Davis, 1997). However, as Crossley (2004) suggested:

Wherever individuals are deemed insane, grouped as such and differentially treated, the potential for resistance exists and the actuality can be identified if one searches hard enough for it. Notwithstanding this, however, such instances of ‘sporadic resistance’ do not amount to social movement formation or activism (p. 164).

Collective resistance to psychiatric discourse occurred in a number of countries, including the USA, the UK and New Zealand from the 1970s. The service user movement in the USA was initially known as the ‘Mental Patients Liberation Movement’. Its members focused on the lack of basic human rights afforded to

patients in the American system, especially in the context of involuntary hospitalisation (Frese & Davis, 1997). The experience of psychiatric treatments in asylums was depicted by those who had gone through the process as a damaging experience and an abuse of human rights (McLean, 1995). Chamberlin (1990), an early activist, noted that the movement was influenced by the black, women's and gay pressure groups that defined their identities and established priorities to "emerge from subjugation" (p. 323). Likewise, the members of the American service user movement defined their identity by sharing personal experiences: "as mental patients began to share their life stories, it became clear that distinct patterns of oppression existed and that our problems and difficulties were not solely internal and personal, as we had been told they were" (Chamberlin, p.325). The growing numbers of groups in the USA were unified by a number of factors, including the stigma of mental health terminology, which was believed by the groups to deepen exclusionary practices (McLean, 1995).

In the 1970s the UK also witnessed the emergence of the service user movement through the 'Mental Patients Union'. The group was comprised of persons labelled with mental illness, and their associates, who fought politically against mainstream psychiatric treatment, including the practice of incarceration (Spandler, 2006). A number of organisations collectively convened as 'The Mental Health User Movement' (MHUM), campaigned, lobbied, and organised activities to oppose oppressive policy, unmask stigmatising media, and highlight civil liberty issues (Rogers & Pilgrim, 1991). As with the USA movement, psychiatric terminology was noted as a significant power that marginalised the mentally ill (Rogers & Pilgrim, 1991):

Part of the attempt to change the agenda about mental health is revealed in the strong views expressed about terminology: 'distress' not 'illness'; 'survivor' not 'consumer'; 'inmate' not 'inpatient'. The MHUM has recognised the power of language in maintaining and changing power relationships and thus mirrors similar concerns in feminist and black movement. The notion also of 'tokenism' (instead of genuine 'representation') is often cited in these groups, as part of a counter-terminology to existing professional discourses. The latter

are associated with maintaining stigmatising and marginalising processes (p.142).

Non-patients were often excluded from early service user groups because they were seen as monopolising and reforming; bringing outsider stigmatisation and thereby exerting internal oppression on ex-patients (Chamberlin, 1990). The development of the consumer movement in New Zealand was influenced by the 'New Zealand Trust for the Foundations of Mental Health', registered in 1974. Originally focused on the perinatal period of life as a precursor to mental wellbeing, the trust entered the public realm with a 'telethon' in 1977 to raise finances, launch public awareness of mental health factors that contributed to psychological stress, and promote community-based programmes (Mental Health Foundation of New Zealand, 2008). Board member Basil James noted that the 'telethon' acted to "destigmatise issues of mental health ... [p]eople became aware that it was not an issue of shame ... it was an issue of very widespread disability but also an issue of hope" (Mental Health Foundation of New Zealand, p. 38). The 1980s saw a name change to the 'Mental Health Foundation of New Zealand', which conducted national and international seminars and conferences with a number of renowned speakers, including Judi Chamberlin, a founding member of the service user movement in the USA.

The mid-1980s witnessed the emergence of New Zealand's service user movement named 'Psychiatric Survivors', founded by a user of psychiatric services, Mary O'Hagan, who was based with the Mental Health Foundation of New Zealand. O'Hagan was influenced by hearing Judi Chamberlin on the radio in 1984, which led to her participation in a conference in Wellington in 1985 (Mental Health Foundation of New Zealand, 2008). Proclaiming the reality of exclusion, O'Hagan (2014) declared:

At the first plenary I got up and spoke. I told the conference how invisible and silenced I felt. I asked them why there were so few service users there. I made a plea for them to take our views seriously and include us in their discussions. And I made a pledge to myself to create an advocacy organisation run by service users (p. 82).

O'Hagan (p.150) recalled the "heady excitement of people who had just found freedom" at the initial service user meetings in 1987. She also noted resistance to the concept of service user inclusion from those who influenced and delivered mental health services:

Our voice was marginalised by the Interest Group. They set the agendas, chaired the meetings and dominated the discussions. We were a small minority, a new stakeholder that would not have been represented on such a group even two years beforehand. As the others talked, we survivors felt as though we were almost drowning in their entrenched conservatism and patronising attitudes. When we did get the opportunity to express our views, we soon felt submerged again by the powerful voice of the status quo. The professionals at these meetings pronounced their views from a high sturdy platform built by historical privilege, educations, money and authority (p. 154).

As O'Hagan cautioned, coalition with government agencies to access resources and power risked concord with psychiatric discourse. Notably, the popular 'Recovery Inc.' from the USA promoted psychiatry and mental health services as irreplaceable (Galanter, 1988). Conversely, the 'Campaign Against Psychiatric Oppression' from the UK aimed to abolish psychiatry as part of the struggle against capitalism and was credited with less than 8 members (Rogers & Pilgrim, 1991), suggesting that resistance to, rather than coalition with psychiatry had much less support.

Service user groups attempted to infiltrate institutions involved in the design and planning of mental health services to influence decision making. For example, 'MINDLINK' a UK group, cited in Rogers and Pilgrim (1991), understood the limitations they faced:

I think the users' movement is at too early a stage to have much impact on planning. But in a lot of areas there are users involved in planning and we are getting people on to health authorities and joint planning teams. But maybe not in large enough numbers and quickly enough to be influential (p. 140).

The expressions of outrage from service users experiencing a lack of power and rights in hospitals highlighted an emerging resistance towards psychiatry, as an example from Rae Unzicker (1989) shows:

I was angry that I'd been crazy, but I was even more angry at the inhumane, hurtful, degrading, and judgemental "treatment" I'd been subjected to. Even when I knew, in that seclusion room, that the "help" was not helpful, I believed I was powerless, that I'd need "help" the rest of my life, that a doctor would have the answer, and that there was something wrong with me for not having the key to extract it. (p. 71).

Resisting feelings of powerlessness, the concept of empowerment became a fundamental ideology in the service user movement (McLean, 1995). Empowerment was used to promote awareness that in order to overcome illness, persons with mental illness needed an environment incorporating self-determinism in treatment interventions and in the broad spectrum of life experiences. However, the term empowerment was a conceptual problem due to its diverse meanings, with immense variations regarding the definition of the problem, the nature of the solutions/(s), and the question over who should produce and control production of the solution/(s) – the very sources of political debates among these different actors (McLean, p.1056).

Nonetheless, empowerment was generally represented as a form of self-help to portray persons with mental illness as competent individuals, in contrast with the negative images created by psychiatry (Chamberlin, 1990).

The development of self-help alternatives, such as the 'Hearing Voices Network', that enabled persons experiencing forms of madness to avoid medical interventions, developed in the 1980s. The group offered an alternative discourse to the traditional view of psychiatry by using coping strategies as a replacement for medications. Initially established in the UK in 1988, the 'Hearing Voices Network' aimed to promote non-clinical strategies for persons to learn how to cope with voices. The experience of hearing voices as a form of altered sensory stimulation and the

strategies involved in coping required a non-judgemental environment where exploration of the experience with peers could safely occur (Martin, 2000).

A non-judgemental environment was seen as crucial, in that people who experienced voices might not otherwise openly discuss their experiences for fear of being labelled a psychiatric patient (Romme, Honig, Noorthoorn & Escher, 1992). Ownership of the experience of hearing voices supported the process of empowerment through emphasis on self-determinism and autonomy, as noted by Ron Coleman (2016), founding member of 'Hearing Voices Network (UK)':

The journey through madness is essentially an individual one, we can only share part of that journey with others, most of the journey is ours and ours alone. It is within ourselves that we will find the tools, strength and skills that we require to complete this journey for it is within ourselves that the journey itself takes place (para. 35).

Ownership of healing mental distress rather than a reliance on mental health services was remarked upon by Debra Lampshire, a prominent New Zealand author and teaching fellow, regarding her stay in a psychiatric hospital, "I sat for eighteen years waiting to be cured by health professionals, believing that they could cure me. And it took me eighteen years to realise that they couldn't. The only person that could heal me was me" (Attitude Live, 2015).

Patricia E. Deegan, a clinical psychologist, ex-service user and advocate, who was a notable public critic of mental health services from the 1980s in the USA, advocated harnessing human strengths to overcome adversity. Her use and explanation of the word recovery was initially identified as the lived experience of rehabilitation (Deegan, 1988). The concept of hope and the need for a nurturing environment to overcome the devastating impact of illness was highlighted as a form of self-determinism (Deegan, 1987); "[f]irst we must be committed to changing the environments that people are being asked to grow in" (p. 9).

Recovery was now presented as a process of growth through acceptance:

Recovery does not refer to an end product or result. It does not mean that one is "cured". In fact, recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find our

personal limitations are the ground from which spring our unique possibilities. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus recovery is a process. It is a way of life (p. 13).

Recovery discourse stressed the value of peer support, believed by O'Hagan (2010) to be a natural mechanism that occurs when persons with mental illness are together. Peer support relationships enabled the validation of knowledge surfacing through the voices of persons with mental illness:

Peer support emphasises whole of life issues, our strengths, and the validity of personal experience. The value of personal narrative is elevated, particularly one that moves people away from an illness and victim identity. A belief in hope and recovery enables people to believe in each other, feel better about themselves and their future, and to make positive changes to their lives (O'Hagan, para. 7).

Within the process of recovery, of healing the self and relationships, personal responsibility was defined as instrumental, "We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do" (Mead & Copeland, 2000, p. 2). Nonetheless, supportive environments that encouraged self-development and equal partnership between the clinician and service user were also highlighted as essential:

Support, in a recovery based environment, is never a crutch or a situation in which one person defines or dictates the outcome. Mutual support is a process in which the people in the relationship strive to use the relationship to become fuller richer human beings. Although we all come to relationships with some assumptions, support works best when both people are willing to grow and change (Mead & Copeland, 2000, p. 8).

For some persons with mental illness, for example, Elyn Saks, a prominent professor of psychiatry in the USA, collaboration with psychiatry was seen as instrumental to maintain wellness. Even though Saks noted that hospitalisation was a toxic experience, she has strongly advocated the role of psychotropic medications to enable mental stability, "what really made it for me was getting on really good meds

and staying on them...I would have had ten years trying to get off meds two or three times per year...and failed miserably each time” (Attitude Live, 2015).

The construction of a new perspective regarding mental illness did not occur in isolation from the political systems of the era. The ideology of the service user movement occurred during a period where the political climate of neo-liberalism supported the motives and values of the movement. Knowledge of the self as an individual, with self-determination and a value of social inclusion, fits the ideology of liberalism (Rimke, 2000). Self-help can be achieved when the self-helper is “skilled in his or her own subjection, in organizing and sustaining some stable operative unity among the multitudinous, divergent effects of the techniques that produce intelligible selfhood” (Rimke, p. 63). The service user movement also occurred during a period of deinstitutionalisation, driven in part by the deregulation of services that was core to the new political ideology of neo-liberalism, and which began to radically change the provision of services. New arrangements for the delivery of healthcare based in the community, which were financially viable, were sought at the end of the 20th century, resulting in opportunities for services users to increase their power as stakeholders (Tomes, 2006).

Whether a consequence or a cause of service delivery change (Tomes, 2006), the service user movement had begun to normalise a new perspective regarding mental illness through the production and circulation of recovery discourse by the beginning of the 21st century. Recovery was represented as an internal process that aided healing; a journey that aimed to increase life satisfaction (Mental Health Foundation, 2008) Recovery was used by service users as a technique of power to resist oppressive psychiatric practices and increase power as stakeholders in mental health service provision. Recovery was also used by service providers to support new ways to administrate and manage the health sector, as represented through the concepts of managerialism and consumerism. The last three chapters explored psychiatry as it evolved in the 20th century and the resistance from within and without the discipline.

The next chapters investigate the emerging concept of recovery through research and policy documents; the promotion of the representation of psychiatric patients as

citizens from the 1950s; and the use of disciplinary and panoptic power to shape the behaviours of persons with mental illness and the mental health workforce.

Chapter 6: Political Ideology and the Promotion of Citizenship

The formulation of mental health national policies, strategic plans of action and local procedures for implementation in New Zealand do not occur in isolation. Influences from other countries and international organisations such as the World Health Organisation (WHO) feed into and are influenced by socioeconomic and cultural political factors. Contemporary New Zealand policy, such as 'Rising to the Challenge' (Ministry of Health, 2012), makes reference to the WHO regarding policy objectives or global statistics that are used to inform service delivery.

This chapter gives a brief analysis of an international document from the 1950s written by the WHO and titled 'The Community Mental Hospital: Third Report of the Expert Committee on Mental Health'. A step back in time can "call into question the supposed linear evolution of history" (Tamboukou, 1999, p. 203) by noting discontinuities in discourses. In the previous chapter, the service user movement was described as "collective networks of resistance" (Crossley, 2002, p.143) to psychiatric discourse, formed in the 1970/80s to collectively challenge a number of issues, including language and labelling (Deegan, 1987; Rogers and Pilgrim, 1991), the oppressive power of psychiatry (Chamberlin, 1990) and degrading treatments (Unzicker, 1989). 'The Community Mental Hospital' (WHO, 1953), has been included here to note an international conference, comprised of psychiatrists from North and South America, parts of Asia and Europe, who endorsed the formation of peer support networks for persons with mental illness, to tackle exclusion and promote citizenship, and to challenge some of the conditions experienced in psychiatric hospitals. The report, which advocated against the overuse of hospitalisation and involuntary commitment for persons with mental illness, demonstrates the fluidity of discourse relative to political ideology.

'The Community Mental Hospital' (WHO, 1953), proposed the establishment of community mental health services to avoid the overuse of hospitalisation. The report highlighted how services based in the community could educate the general population about mental health and help to prevent the prevalence of mental illness.

The 1950s saw the introduction of new psychotropic medications as a treatment option for persons with severe and enduring illnesses, creating an opportunity for policy to consider alternatives to long-term hospitalisation (Gronfein, 1985). New medications supported a decrease in the average admission stay of patients from years to months, fostering the conditions for the possibility of community care (Scull, 1981).

The WHO (1953) report began by noting a need for mechanisms that would identify the prevalence of psychiatric morbidity in order to support the administration of bio-power techniques, such as prevention, to improve health. Identifying solutions to manage the health of populations, and support the promotion of new norms to shape practices (Dreyfus & Rabinow, 1982), the document proposed the provision of education to foster good mental health relative to developmental stages of life. Solutions were aimed to reduce prevalence and thereby reduce hospitalisation.

For persons with mental illness, hospitalisation as a form of custodial treatment was proposed by WHO (1953) to be only necessary for the “most flagrant of psychiatric disorders” (p. 5), where individuals posed a risk to themselves or others. The need for hospitalisation was suggested statistically as one bed per 1,000 of a country’s population requiring mental health input. Instead, treatment in out-patient clinics was proposed as a new technique to prevent the hospitalisation of persons who could receive treatment in the community, and support patients after hospital discharge.

In New Zealand, planning for new psychiatric hospitals terminated in the early 1960s and within the next decade the number of hospital beds available became static, denoted by Brunton (2011) through the shift to community care: “[e]very mental hospital patient was assessed, and 26% of psychiatric and 46% of mentally disabled patients were recommended for accommodation outside the major psychiatric hospitals” (p. 5). Although the rise of neo-liberal attitudes promoting independent citizens in 1970s New Zealand (Belgrave, 2012) supported the move towards community care, the WHO had growing influence on health care service provision norms globally, from the 1950s onwards (Brown, Cueto & Fee, 2006).

Concerns regarding oversight, stigmatisation, exclusion and the potential lack of productivity for patients who were discharged from in-patient care was highlighted by WHO (1953):

When the patient leaves the hospital, one of two attitudes is often observed: either he tends to deny his illness and to sever all contact with the hospital and its doctors; or else he is overcome with anxiety caused by a more or less conscious fear that he will be incapable of confronting his responsibilities and supporting the moral isolation and, often, the sheer loneliness which await him outside (WHO, pp. 12-13).

Visibility is implicated by Foucault (1984e) as crucial to disciplinary techniques, in that, it “is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility” (p. 199). As a remedy to provide oversight and promote social inclusion, peer support mechanisms, supervised by healthcare professionals, were suggested as a way to maintain surveillance, overcome obstacles preventing social rehabilitation, and support some patients to access power as competent individuals:

Old-patients’ clubs have been found an excellent way of meeting these problems. They are constituted by groups of old patients and are preferably run to a considerable extent by the patients themselves. In fact such patients are more likely than any others to understand those who have undergone the same difficulties as themselves (WHO, p.13).

The experiential knowledge of ex-patients regarding the loss and restoration of mental health was legitimised in the report through an acceptance that patients were “more likely than any others” (WHO, p. 13) to understand issues concerning hospitalisation and community reintegration, supporting the development of new roles for patients. As an example of this, ex-patients were encouraged to collaborate with patients based in the hospitals, to support, educate and model the transition into community settings. Developing norms regarding behaviours and standardising the roles and practices of patients for community living supported inclusion through increasing obedience and “mastery of each individual over his own body” (Foucault, 1984d, p. 181). Foucault stated that disciplinary techniques regulated subjects

through “the meticulous control of the operations of the body, which assured the constant subjection of its forces and impose on them a relation of docility-utility” (p. 181). Formal peer support mechanisms within the hospital setting were also encouraged in the report as a technique to develop a “therapeutic community” (p. 18) as opposed to a hospital-prison environment.

‘In-patient clubs’ were noted as a technique in “modifying effectively the atmosphere within the hospital” (WHO, p. 23). Defined as a mechanism to support the self-regulation of behaviours, clubs were encouraged that spring from the initiative of the patients themselves as a result of their most concrete needs and even sometimes of their intolerance towards the situation in which they live... thus we find groups being created to negotiate with the kitchen or general services...the aggressive tendencies it manifests can be directed towards useful activities which are derived in a logical manner from these very intolerances (p.23).

The report encouraged the formation of a co-operative relationship between staff and patients to support the latter to access power and thereby begin to meet their own needs and address their own problems, reflecting neo-liberal ideology: “If patients protest against inaction and boredom they should be encouraged to create clubs for the organization of workshops, series of conferences, musical groups, and various instruction courses” (WHO, p.23).

The formation of ‘In-patient clubs’ in hospitals, supported by ex-patients and overseen by staff was representative of Foucault’s (1975/1984d) concept of disciplinary power through the targeting of subjects in ways that increase their productivity and compliance with norms. Foucault (1984e) suggested that “the success of disciplinary power derives no doubt from the use of simple instruments: hierarchical observation, normalizing judgement, and their combination in a procedure that is specific to it – the examination” (p. 188). Rules and standards of conduct, which were encouraged by hierarchical positions as therapeutic activities, would be internalised by the patients in order to access power. The clubs could enable the development of productive behaviours for patients by the patients. Activities that were depicted as therapeutic, and which supported access to power, as well as regulating behaviours, were less likely to be resisted.

Techniques that reflected liberal governance ideology encouraging the conditions of self-regulation, self-improvement and responsibility in individual patients had existed in the asylums in the moral treatments of the physicians Pinel and Esquirol, (as discussed in chapter three). Conversely, 'The Community Mental Hospital' (WHO, 1953), supported the use of liberal governance techniques at this time by representing patients as knowledgeable about mental illness, recuperation and community integration, and thus promoting self-sufficiency.

The development of techniques such as peer education and modelling, encouraged in psychiatric discourse, demonstrates a shift of knowledge/power from psychiatry to persons with mental illness and was made possible through representing patients as knowledgeable. However, peer support mechanisms also signified the potential for a covert form of psychiatric power that aimed to regulate behaviours through a productive form of disciplinary power which emphasized knowledge norms to attain social inclusion and thereby, citizenship.

Central to the social integration of persons institutionalised in asylums was the "requirement to assume the status of being the subject of their lives, upon the ways in which they fashion themselves as certain kinds of subjects, upon the ways in which they practice their freedom" (Burchell, 1993, p. 276). As a portent for significant change occurring over the next half century, 'The Community Mental Hospital' (WHO, 1953) helped to define a new representation of persons with mental illness as potential citizens so that "life within the hospital should, as far as possible, be modelled on life within the community in which it is set" (p. 19). The report, through the promotion of peer mechanisms, encouraged the sharing of personal experiences between persons with mental illness to support community integration. It may have also contributed to the rise of the service user movement itself, through legitimising the humanity, knowledge and competency of persons with mental illness in institutions and general society.

The 'Community Mental Hospital' (WHO, 1953), is an example of how socio-political ideology can inform discursive practices. The report's inclusion in this research does not signify that recovery emerged from psychiatric discourse, or that the service movement had no grounds to resist psychiatric discourse that, from the 1950s, had encouraged the empowerment of persons with mental illness. From a socio-political

perspective, the report defines the emergence of neo-liberalism within the arena of mental health service provision.

In the next chapter, the strengthening ideology of neo-liberalism is reflected through shifts in mental health service provision between the 1950s and the 1990s, notably through the closure of the large psychiatric hospitals and the implementation of community-based care. The emergence of recovery discourse to support persons with mental illness to integrate into community settings is noted in health policy, from the 1990s, that shaped a new mental health workforce.

Chapter Seven: A Panoptic Power

The personal narratives of persons experiencing mental illness, mental health services and recovery emerged in New Zealand and other countries such as the UK, USA and parts of Europe in the 1980s. Recovery discourse was circulated during the 1990s through research that advocated for recovery in mental health policy such as Anthony's (1993) 'Recovery from Mental Illness'. This chapter traces the development of recovery discourse as it has appeared in New Zealand health policy and strategic planning between the end of the 20th century and the present. National health care reform, mandating the closure of large psychiatric hospitals and the emergence of community-based care, which was discussed briefly in the previous chapters, is explored further through the perspective of neo-liberal management techniques that aimed to change the provision of mental health services. It is argued here that neo-liberalism shifted the power dynamics in psychiatric discourse for persons with mental illness through their representation as consumers. Managerialism and consumerism are investigated to show how new practice models informed the emergence of recovery as an approach for working with people experiencing mental illness.

By the 1990s, recovery, from the perspective of the service user movement, was acknowledged in the literature (see, for example, Anthony, 1993; Roberts & Wolfson, 2004) as a new vision for strengthening community mental health services. Promotion of recovery as a clinical practice approach was endorsed by research (Anthony, 1993, Barker, 2001) and later, by policy to support the integration of persons with mental illness into the community following the closure of large psychiatric hospitals; a process known as deinstitutionalisation. New Zealand mental health policy in the 1990s thus reflected the restructuring of mental health services which had, for 200 years, been chiefly provided in government-managed institutions.

The process of deinstitutionalisation supported the ethos of care in the community by moving care provision to smaller units attached to general hospitals and by reducing

hospital admission rates (Brunton, 2005). In the 1970s New Zealand saw economic and social restructuring of the welfare state, which led to the closure of the large psychiatric hospitals over the next twenty years and created the conditions for new opportunities for treatment, as noted by Joseph and Kearns (1996):

Although the debate on the restructuring of the health care system paid more attention to generic issues of funding and management than to the desirability of particular treatment modalities, there were inevitable consequences for the way in which services could be delivered (p.181).

Deinstitutionalisation as a term also encapsulated an awareness that the institutionalised roles and routines generated by asylum life could create functional difficulties for discharged patients, affecting their ability to integrate into the community (Brunton, 2005; Coleborne, 2012; Hall, 1988). A shift in the representation of persons with mental illness from patients to consumers of mental health services aimed to reduce barriers to community integration through the neoliberal belief that a focus on individual interests would benefit society as a whole.

Consumerism implied a form of citizenship (Mayer, 1981) for persons previously incarcerated in psychiatric hospitals, who could now access mental health services in the community and participate in service provision. Mental health services were expected to involve service users in tasks, such as developing peer support mechanisms, to demonstrate their inclusion in service planning and delivery (Stickley, 2006), and thereby created new positions in the mental health workforce for persons with mental illness. The consumerist approach reflected growing attention to human rights for service users, who were now depicted as autonomous individuals who could choose between services and be empowered by their choices (Lupton, 1997). Alternatives to psychiatry in the form of self-help and peer support were promoted through articles, meetings and conference presentations by persons with mental illness (Leete, 1989; Lehman, 2000). In New Zealand policy, attention was being paid to diversity in the population in terms of different treatment needs and socio-cultural differences, such as the rights of Maori (Ministry of Health, 1994, Minister of Health, 2005).

The rights of Maori were initially acknowledged during the 1840s from the signing of the Treaty of Waitangi between the indigenous Maori population and the colonising British crown. The English text of the Treaty established British sovereignty with disputable recognition of Maori rights, such as land ownership (Walker, 1984). Maori advocates have continued to highlight barriers to rights, such as the lack of self-determinism promised in the Maori text and the lack of opportunities for self-reliance. Health is a Maori rights issue, with Maori perspectives on health differing from Western approaches through a focus on the wellbeing of the community rather than individual dysfunction (Durie, 1985; 2001). Maori rights concerning health were discussed in policy by the end of the 20th century, in 'Looking Forward: Strategic Directions for the Mental Health Services' (Ministry of Health, 1994):

Mental health institutions in the past have not provided for the holistic healing needs of Maori. Mental health services are still mainly monocultural with an emphasis on clinical treatment. Services in the future will need to be culturally safe and be able to provide treatment at a spiritual, physical, emotional, and cultural level (p. 9).

The needs of the Maori population were specifically targeted in the publication of 'He Korowai Oranga: Maori Health Strategy' (Ministry of Health, 2002). Stating commitment to the Treaty of Waitangi, the strategic document highlighted the concept of partnership, participation and protection with an overall goal of reducing health inequalities:

[T]he goal is active participation by Maori at all levels of the health and disability sector in decision-making, planning, development and delivery of health and disability services...to identify what is needed to encourage health as well as prevent or treat disease (p. 9).

Although not specific to mental health, 'He Korowai Oranga' replicated consumer ideology through the emphasis on greater Maori control and contribution in health provision, stating recognition of Maori cultural values to improve Maori health as "[u]sing models that operate within and through te ao Maori can be a very effective means of reaching Maori whanau. For example, health promotion initiatives that use

an approach based on the Maori world have achieved effective results” (Ministry of Health, p. 12).

A deregulatory approach to health care service provision by the end of the 20th century increased the diversity of available health services, such as Maori models of care. There was an emergence of neo-liberal business models within mental health policy, demonstrated by an emphasis on funding, resource allocation and competitiveness between services, thus rendering health care a commodity (Pellegrino, 1999). Managerial terms, such as cost-effective practice and accountability, appeared in New Zealand mental health service provision policy in the 1990s (Ministry of Health, 1994; Ministry of Health, 1997) as strategies to improve community-based services. Management techniques were represented through quality assurance procedures and best practice that endeavoured to benefit consumers (Wong, 2004).

The implication that the changes to service provision were in the interests of consumers made it difficult to critique the increase of management processes (Gilbert, 2005). Through emphasis on service improvement, neo-liberal management techniques were able to assert a dominant position in the provision of mental health services previously governed by psychiatric discourse. The move towards consumer autonomy and managerial dominance also shifted the balance of power between patient and psychiatrist, which Hunter (1996) noted as

[A]n attempt to shift the balance of power from doctors to managers. Notions such as clinical audit, evidence based medicine, clinical protocols and guidelines are all intended, if not always overtly, to constrain clinical autonomy and make medical decision-making better informed, responsible and conform to a common purpose (p. 807).

During the 1990s, mental health service provision in New Zealand was shaped by two key policies (‘Looking Forward’, Ministry of Health, 1994; ‘Moving Forward’ Ministry of Health, 1997), which aimed to better define the mental health population by gathering statistical information on service use, and supporting people to access

services. In 'Looking Forward: Strategic Directions for the Mental Health Services' (Ministry of Health, 1994), resource availability and improved expenditure were seen as key to the successful implementation of services. Responding to concerns regarding the lack of accountability of mental health services to the welfare of patients and the general public, cited in the Mason report (Mason, Ryan & Bennett, 1988), the government instituted a number of strategies.

One such strategy was benchmarking, an accountability tool adopted from international studies and service provision policy in Australia, which provided information to funders on service provision, outcomes, and user satisfaction (Wynn Williams, 2005). Benchmarking a percentage of the population requiring mental health services was proposed in 'Looking Forward' (Ministry of Health, 1994) to address the lack of service user data, and as an initial means for the allocation of funding, by defining three percent of the population as experiencing significant mental illness:

The 3 percent benchmark for mental health services for the general population and for youth was adapted from international studies, in particular a New South Wales estimate...that 2.6 percent of the population require general mental health services for adults, youth and children... adapted for New Zealand by taking into account demographic factors, the prevalence rates for Maori, and service-use patterns (p. 2).

Community care was mentioned in 'Looking Forward' (Ministry of Health, 1994) as the new direction for mainstream mental health services:

Community mental health services will become the linchpin for the mental health system. They will be the primary focus for care, providing services to all members of the community. Use will still be made of residential services – with consumers moving back and forth between community and residential care depending on their needs (p. 15).

Community care was also recorded in the document as “the most cost-effective way of providing mental health services” (Ministry of Health, p. 3) through “health promotion and mental illness prevention, assessment and early intervention, treatment, rehabilitation, and continuing care” (p. 6). A responsive mental health

workforce was acknowledged as a priority so that “the needs of those with psychiatric disabilities – needs which they often cannot advocate for themselves – are heard and recognised” (p. 10). By claiming that persons with mental illness were generally not able to advocate for themselves, the document reflected a stigmatising perspective of helplessness that the service user movement had challenged in the previous decade.

Recovery, although not explicitly named as such, underscored the principles of ‘Looking Forward’, by “encouraging services that empower individual consumers and their families/whanau and caregivers” and “encouraging services that enable people of any age, culture, gender, or individual interest to fully participate in society” (Ministry of Health, 1994, p. 5). The document’s successor, ‘Moving Forward: The National Mental Health Plan for More and Better Services’ (Ministry of Health, 1997) focused on increasing and improving community-based service provision and service access. The plan was notable in highlighting the need for services to empower service users through their increased participation and control in service provision, as recorded in the strategic plan:

Over the life of the National Mental Health Plan, groups of individual consumers are likely to consolidate their networks, become more representative of consumers overall, and further develop their skills and knowledge base. It is also expected that more consumers will gain employment in various capacities in the mental health sector. As well, implementation of the National Mental Health Standards will mean increased involvement by consumers. There needs to be more training, to better support consumers in all these activities (p. 22)

‘Moving Forward’ (Ministry of Health, 1997), stated that service access and participation was impeded by stigmatisation. By the end of the 20th century, barriers that prevented the social inclusion of persons with mental illness because of stigmatisation and discrimination were highlighted in New Zealand mental health service provision by the ‘Blueprint for Mental Health Services in New Zealand: How Things Need to Be’ (Blueprint) (Mental Health Commission, 1998). The commission, established by the government to identify and support policy direction, demanded

that the mental health sector eliminate discrimination from within its own services, as well as working with other sectors and the general community to support discrimination prevention strategies. The commission recorded that

It is almost inevitable that when people experience discrimination from others, they will internalise the messages they are given. The mental health workforce must recognise this, and develop a recovery approach that gives service users hope, a sense of self-worth, and a sense of belonging (p. 20).

The term recovery appeared in the Blueprint (1998) as a new approach to guide the delivery of services:

The focus of this Blueprint is on a recovery approach in service delivery. This approach is consistent with the guiding principles of the Strategy, which state 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 (p. vii).

The document defined recovery as appropriate to a New Zealand context by noting its relevance in both Western and Maori ideology:

The concept of recovery can be applied to most beliefs about the origins and nature of mental illness – biological, psychological, social, or spiritual. It can be also easily applied to holistic approaches such as the Whare Tapa Wha model which identifies four dimensions of health – taha wairua (spiritual), taha hinengaro (mental and emotional), taha tinana (physical), and taha whanau (family) (p.15).

The empowerment of service users through the use of recovery discourse was defined in the Blueprint (1998) as a key objective for mental health services. DHBs were asked to collaborate with a broad range of services to enable “a focus on recovery, so that services can recruit people with as much knowledge and skill in facilitating wellness as in treating illness” (p. 17). Recruitment of “[p]eople with

experience of mental illness, with the right aptitude and skills, should be encouraged to seek employment in mental health services” (p. 17). The emphasis on wellness marked a shift away from the traditional model of health professionals treating illness through, for example, the inclusion of service user role modelling. The role of “facilitating wellness” (p. 17) indicated the formation of a new mental health workforce, incorporating actors from outside the clinical field.

New Zealand policy at the end of the 20th century emphasised the need for services and clinicians to recognise and accept the empowerment of service users through the provision of a recovery-focused environment. As an aid to tackling discrimination from within the workforce, O’Hagan (2001) defined the ‘Recovery Competencies for New Zealand Mental Health Workers’ in a Mental Health Commission publication that aimed to “redefine recovery for the contemporary New Zealand context” (p.2). Respect for an individual’s autonomy was noted as the foundation of the recovery approach, with the document describing the types of attitudes, skills, knowledge and behaviour required to support autonomy. Understanding the philosophical foundations of recovery through moral reasoning, recognising service user’s personal resources, acceptance of diverse views on illness, and respecting service users through self-awareness and good communication skills were defined as essential for practice. In O’Hagan’s document, awareness of rights, cultural safety and the impact of discrimination via competent personal knowledge, and awareness of the communities and resources available to support the service user, correlated with the Blueprint’s objectives (Mental Health Commission, 1998) on holistic interventions.

Recovery, as a conceptual model of care, was legitimised through policy and supporting documents (Minister of Health, 2005; O’Hagan, 2001) at the turn of the century, creating an environment where the culture of recovery was promoted and eventually internalised by the mental health workforce as discursive practice. Recovery, workforce development, and managerialism were critically engaged in policy by the start of the 21st century, as demonstrated in ‘Te Kokiri: The mental health and addiction action plan 2006–2015’ (Minister of Health, 2006) which aimed to build a mental health and addiction workforce that supports recovery, is person-centred, culturally capable, community-centred and fosters leadership. Action will

also be undertaken to ensure that workforce development is complemented by a sector that fosters a culture of continuous quality improvement, where information and knowledge will be used to enhance recovery and service development (p. 36).

The language of recovery as applied in managerial discourse now played a new role in the monitoring of service provision: “the challenge is to find variables that appropriately capture the unique “lived experience” of recovery in ways that can satisfy the demands for system accountability” (Jacobson & Curtis, 2000, p. 8).

The mental health workforce, which now included service users, was stated by the Minister of Health (2006) as playing “a pivotal role in developing services and leading change towards a culture of recovery” (p. 36). ‘Recovery Competencies for New Zealand Mental Health Workers’ (O’Hagan, 2001) was one strategy to support the development of a recovery culture through the internalisation of recovery principles by the mental health workforce.

Practice competencies developed to guide clinicians and services to provide an empowering environment for service users (Mental Health Commission, 1998; O’Hagan, 2001) can cultivate the self-regulation of clinical conduct. Clinical governance strategies, in the form of competency guidelines, and practice ethics from statutory bodies, such as supervision, aim to facilitate self-development through reflection, education and training (Brown & Crawford, 2003). Clinician self-management, noted by Brown and Crawford to be a style of hands-off management, resonates with “notions of the self-reliant, self-educating, evidence seeking professional incorporated within the clinical governance initiative” (p.79).

Clinical governance techniques that create the notion of clinical autonomy can support the operation and success of policy and managerial goals, as proposed by Wells (2007):

If policy objectives are to be achieved, it is important for managers to avoid conflicts at the practice level that such policy might provoke. The management agenda therefore may be concerned with influencing but not controlling practice in order to steer a course between the demands of central policy and antagonising practitioners (para. 16).

External and internal observation of personal conduct to note disparities between clinical behaviours and service expectations, and the identification and use of strategies to meet professional standards are representative of Foucault's (1975/1984f) notion of panoptic power. Panopticism, according to Foucault (1977) means that

[S]urveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary; that this architectural apparatus should be a machine for creating and sustaining power relations independent of the person who exercises it (p. 201).

Observation of the workforce is achieved through audit and review of information technology, such as computerised clinical case notes, which can be analysed by management to monitor conduct, and which can be horizontally reviewed by peers (Berner, Graupner, & Maedche, 2014). Peer review is able to shape individual behaviours through discussion and through exposure to documentation and the practices described in notes, which can then be normalised in the workplace culture, as suggested by Ball (2010):

Surveillance in the workplace not only produces measurable outcomes in terms of targets met or service levels delivered, but also produces particular cultures which regulate performance, behaviours and personal characteristics in a more subtle way (p. 91).

The normalisation of clinical practice behaviours occurs through the process of supervision, as an example. Professional governance between a supervisor and supervisee occurs through "observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving" (Falender & Shafranske, 2004, p. 7). Supervision is a strategy to control the quality and effectiveness of clinical practices, and facilitate competence and the capabilities of the practitioner (Milne, 2007). Supervision can support the internalisation of workforce cultural beliefs and emphasise statutory competencies; for example, occupational therapists are

“responsible for actively maintaining and developing their own professional competence” (Occupational Therapy Board of New Zealand, 2015, p. 8).

The development of a number of techniques derived from managerialism and consumerism, such as service user participation, professional governance through supervision and self-directed learning, alongside other techniques such as auditing, has encouraged an environment where “the locus of management is increasingly located inside the individual practitioner” (Brown & Crawford, 2002, p. 68).

Techniques that were promoted as a form of disciplinary power in a hierarchical system were normalised in the mental health workforce by the start of the 21st century, enabling a new focus on the service user.

In the following chapter, documents, research, and policy of the 21st century are investigated to note shifts from the use of recovery to regulate the behaviours of clinicians towards techniques that define, guide and measure recovery for service users. Wellness planning is introduced as a technique of disciplinary power that aims to identify and regulate the thoughts, feelings and behaviours of persons with mental illness. Measurement tools that situate a service user within empirically developed stages of recovery are explored as a contemporary expression of objectification by representing service users as a recovery status.

Chapter 8: Techniques of Power and the Resilient Subject

This chapter investigates the use of recovery in New Zealand mental health practices from the beginning of the 21st century. In the previous chapter, recovery was portrayed as a form of panoptic power to shape and regulate the behaviours of the mental health workforce in the interests of consumers. Recovery was situated within the ideologies of consumerism and managerialism and through using the technique of clinical governance. An analysis of discourses pertaining to the changing environment of mental health service delivery in the new millennium notes a shift in emphasis on governance, within policy, from service providers to the users of services. While the governance of mental health workers was further encouraged in new policy during the 21st century, this was now generally depicted as enabling clinicians to better support service users to manage their own health and wellness.

Since the millennium, research (McLean, 2000; Mead & Copeland, 2000; Onken et al, 2002; Salyers, 2009) has shifted attention onto service users, to support their recovery journey by empirically defining and measuring stages of wellness gathered from qualitative and quantitative inquiry. Formal tools that are used as accountability measures to map a person's journey through empirically constructed stages of recovery are investigated in this chapter as a form of disciplinary power and as a contemporary expression of objectification. The emergence of a new term in policy, *resiliency* is introduced, noting its appearance in recovery discourse; and is critiqued as a technique that further situates the problem of mental illness and solutions for recovery, with the individual.

By the start of the 21st century, the change in focus from service provider to service user indicated a shift of emphasis in policy and strategic planning. The techniques of professional governance, managerialism and audit were previously disseminated in policy (Ministry of Health 1994; 1997) and supporting documents (such as the 'Blueprint for Mental Health Services in New Zealand: How Things Need to Be' (Blueprint) (Mental Health Commission, 1998) to encourage a culture of self-development and self-governance in the mental health workforce. Self-governance

was cited as a technique to improve services and empower service users. Workforce cultural change that had improved service delivery was acknowledged in the strategic document 'Te Tahuhu: Improving Mental Health 2005-2015' (Minister of Health, 2005): "[s]pecialist services have expanded to meet the growing needs of people, the quality of services has improved and we have a skilled, capable, committed workforce" (p. iii). The term recovery was introduced in 'Te Tahuhu' to signify acceptance of a new conceptual model that would guide service provision; a new language that indicated responsibility for service users to engage with recovery-orientated services in order to foster and maintain wellness.

Recovery in 'Te Tahuhu' (Minister of Health, 2005) was defined as a "philosophy that underpins services for people and recognises that service users must lead their own recovery, have personal power and a valued place in their whanau and communities" (p. 2). Considered as the "backbone" of service delivery, the document outlined an expectation for services to support people to "make informed decisions to promote their mental health and well-being...maintain their own well-being and participate in society and in the everyday life of their communities and whanau" (p.5). The promotion of service users taking ownership of mental distress and taking a lead role in their recovery reflects some of the desires identified by members of the service user movement (see, Deegan, 1988; Mead & Copeland, as examples).

Policy focus on the service user's lifestyle activities, promoting health and productivity, also reflects neo-liberal ideology that endorses individual responsibility to find solutions to wellbeing (McGregor, 2001). As described by Petersen (1996):

Neo-liberalism calls upon the individual to enter into the process of their own self-governance through processes of endless self-examination, self-care, and self-improvement. Given that the care of the self is bound up with the project of moderating individual burden on society, it is not surprising that it is in the area of health promotion that these developments are most apparent (pp. 48-49).

Released in 2006, 'Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015', which was the implementation plan of the policy document 'Te Tahuhu', encouraged service providers to increase "people's awareness of how to maintain

mental health and well-being” (Ministry of Health, p.12). District Health Boards (DHBs) were requested to work with other organisations to tackle social factors and behaviours that could lead to mental illness.

Emphasis in policy and research on the promotion of behaviours to enable wellness reflect Foucault’s (1963/1989) assertion concerning the use of health standards to regulate physical and moral norms by prescribing the desired behaviours that befit a “model man” (p. 40). Foucault cited medical supervision as a form of policing of social structures; “the definition of a political status for medicine and the constitution, at state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint” (p. 29). An example of the expansion of medicine’s interests beyond the role of diagnosis and treating illness, to promote a healthy lifestyle, can be seen in Te Kokiri (2006) which stipulated the implementation of “other public health strategies that promote the impact of general health and wellbeing on mental health and wellbeing (eg, Healthy Eating – Healthy Action, National Alcohol Strategy, National Drug Policy)” (p. 14). The inclusion of health promotion in policy is an example of population management by circulating health knowledge as norms, which can be internalised by populations as truth (Taylor, 2011). Subtle coercion to engage in or avoid specific activities by linking lifestyle activities with health and well-being denote increasing manipulation of social attitudes in health policy as a productive technology of power (Foucault, 1977/1984d).

Supporting ‘Te Kokiri’s’ (2006) focus on the promotion of healthy lifestyle behaviours and addressing the stigmatisation of the mentally ill, a new representation of recovery appeared in a seminal document titled ‘Destination: Recovery’ (Mental Health Advocacy Coalition, 2008). A key recommendation in the document was a shift in language to ‘mental distress’ and ‘well-being’ as better representations of mental illness and health respectively. A change in language promoted social inclusion for persons with mental illness by moving away from a medical language, blurring health and social perceptions of madness.

Recovery was now defined as “achieving the life we want in the presence or absence of mental distress. The right conditions for recovery are the strength and interrelationships of our self-determination, personal resources, supports, therapies, and our social and economic opportunities” (p.19).

Retaining the philosophy of ‘Te Tahuhu’ (Minister of Health, 2005) self-management was again promoted in ‘Destination: Recovery’ (Mental Health Advocacy Coalition, 2008) as key in the areas of prevention and treatment of distress. Noting barriers to self-management, and social acceptance, and therefore impeding recovery from mental distress, the Mental Health Advocacy Coalition (2008) was formative in highlighting:

The first underlying barrier is that communities, mental health professionals and even people with mental distress themselves tend to believe that madness is entirely negative and has no value. This belief generates fear, pity, discrimination, exclusion and the coercion of mad people. Unlike other extreme experiences such as intense grief or surviving a war, society still does not legitimise madness or nurture a pathway through it towards growth or recovery (p.25).

Concerns regarding discrimination highlighted in the first Blueprint (Mental Health Commission, 1998) were echoed in ‘Destination: Recovery’ (The Mental Health Advocacy Coalition, 2008). The report argued that a change in societal attitudes was still needed to help persons with mental illness to overcome discrimination. Government initiatives to address the public stigma of mental illness, such as the ‘Like Minds Like Mine’ campaign in the late 1990s, had attempted to tackle discrimination through the media, by increasing visibility and leadership options for persons with mental illness. However, stigmatisation, affecting community integration, still remained a major barrier to recovery ten years into the campaign (Ministry of Health, 2007).

Stigmatisation deriving from the objectification of persons with mental illness by labelling (Foucault, 1963/1989; Goffman, 1969; Laing, 1964), as described by the anti-psychiatry movement, was discussed in Chapter four as being a major barrier to

social inclusion. There are other factors that contribute to social exclusion, which are very variable, and interrelated with each other.

Social exclusion can relate to social status; for example, socially disadvantaged groups such as those experiencing low socio-economic status are at higher risk of being stigmatised. Socially disadvantaged groups have fewer opportunities and resources in relation to accessing treatment; they may have inadequate knowledge about health and services, and lack of finances to afford health care (Link & Phelan, 2006). Social exclusion can relate to the general beliefs a population may have about the causes of mental illness. Greater levels of fear and distrust of persons with mental illness exist in social groups that believe the causes of illness are due to personality and loss of control rather than an underlying medical reason. Portraying mental illness and associated behaviours as personality-driven is more likely to perpetuate a belief that the mentally ill are dangerous and unpredictable (Dietrich, Beck, Bujantugs, Kenzine, Matchinger & Angermeyer, 2004).

To counteract the stigmatisation of mental illness, a new approach to address mental distress and promote well-being emerged in the second decade of the 21st century. Self-responsibility of individuals, their families and local communities to endure adversity and maintain wellness was proposed in the document 'Blueprint II: Improving Mental Health and Wellbeing for all New Zealanders, How Things Need to Be' (Blueprint II) (Mental Health Commission, 2012). A multi-agency approach to care was outlined to increase "the capacity of individuals to cope well under adversity" (p.11). 'Blueprint II' advocated a number of strategies to support wellbeing by "enhancing the protective factors and diminishing the risk factors" (p.29) of health, including lifestyle changes in the form of work productivity and alcohol intake, as respective examples. The document introduced the term *resiliency*, which has been defined as "the mental state of being able to withstand stress or adverse circumstances or to recover quickly from their effects" (Lentzos & Rose, 2009, p. 242).

Resiliency, interrelated with recovery, was described by the Mental Health Commission (2012) as a means to enhance social inclusion for persons with mental

illness, through their development of skills, increasing their ability to be productive members of society and thereby creating a sense of equality. As a form of disciplinary power, noted by Joseph (2013):

resiliency fits with a social ontology that urges us to turn from a concern with the outside world to a concern with our own subjectivity, our adaptability, our reflexive understanding, our own risk assessments, our knowledge acquisition and, above all else, our responsible decision making (p. 40).

Resiliency-building strategies resonate with aims for “constructing and interpellating neoliberal subjects...who are ‘free’ to take responsibility for their own life choices, but who are expected to follow competitive rules of conduct” (Joseph, 2013, p. 42). The neo-liberal deregulation of central agencies that historically protected individuals from adversity, known as the welfare state, supports a culture of individual preparedness and responsibility (Amin, 2013), that can be seen through the promotion of self-management techniques befitting health and lifestyle standards.

Resilience is indicative of a move away from health care models that focus on disease or deficiency towards a more optimistic approach that incorporates a person’s strengths and adaptive forms of functioning (Schoon, 2006). By supporting the deregulation of responsibility and ownership away from government agencies towards subjects, the concept of resiliency has suited an environment of financial constraints impacting on service provision, such as noted in the second Blueprint (Mental Health Commission, 2012).

The Blueprint II (Mental Health Commission, 2012) had a focus on system performance and resource allocation in relation to significant financial constraints impacting service provision. Reducing the cost for each service user in a climate of increased system performance was seen as manageable through further deregulation of services. Deregulation included a shift from specialist services to “other organised mental health and addiction responses including health promotion, self care, primary, community and DHB provided services” (p.21).

Cost-effective service provision through health promotion and self-care strategies was further elucidated in ‘Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017’ (Ministry of Health, 2012). To monitor the

effectiveness of self-care interventions, Key Performance Indicators (KPIs), a measurement tool for collecting specific data on clinical intervention outcomes that are reported to government, were defined in the document as a way to enhance system performance.

Monitoring people with specific need and conditions was encouraged through information gathering on service user goals, service supports, and outcomes achieved, “including self-determined outcomes” (p.24). However, it is questionable whether self-determined goals are such or whether they are shaped through bio-power techniques where health norms and social values have been internalised by subjects.

Monitoring techniques with a focus on the individual, rather than their social situation and historical antecedents, were endorsed in ‘Rising to the Challenge’ (Ministry of Health, 2012). Respectful partnerships between clinicians and service users, characterised as “supporting them to make informed choices, taking a holistic approach, implementing collaborative note writing and recovery planning and proactively involving friends, family and whanau” (p. 26) were prioritised. Collaboration with clinicians, recognition of health norms and engagement with community were established as necessary conditions for service users to engage with in the process of recovery. Tools supporting knowledge development for self-care and resiliency, such as the ‘Wellness Recovery Action Plan (WRAP)’ (Copeland, 2002), were considered by ‘Rising to the Challenge’ (2012) as an opportunity for holistic and collaborative practice that empowered the service user and reduced costs.

Wellness planning tools incorporate a breakdown and description of factors pertinent to an individual’s sense of wellness and ill health. The WRAP (Copeland, 2002) is a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms. It also includes plans for responses from others when a person’s symptoms have made it impossible to continue to make decisions, take care of him/herself and keep him/herself safe (p. 129)

Plans are jointly constructed by the service user, clinicians involved, and other relevant persons or agencies concerned in their care. Recovery goals are time-limited with defined responsibilities for those involved in the plan. Actions to meet goals are designed to reduce or eliminate behaviours that hinder wellness and that lead to the achievement of specific tasks identified by the service user and their supports, such as family or clinical staff.

In order to achieve well-being through goal setting, those developing the plans identify situations that can trigger distress. Known as early warning signs, responses to stress can be suggestive of a relapse to an acute state of ill health. Strategies to self-manage early warning symptoms or distress caused by environmental factors are developed in the plans to increase resiliency, as recognising “early warning signs and reviewing them regularly will help the person to become more aware of these early warning signs, allowing the person to take action before the signs worsen” (p. 136).

Users of WRAP self-monitor symptoms, thoughts and behaviours as well as seeking feedback from family and mental health clinicians to monitor health, enlisting others in surveillance. Future interventions can be mapped; for example, in times of crisis, advanced directives note desired interventions when responsibility for care is taken over by mental health services (Copeland, 2002). Recovery planning can also include behavioural activation, a technique to support engagement in adaptive activities through “self-monitoring of activities and mood, activity scheduling, activity structuring, problem solving, social skill training, hierarchy construction, shaping, reward, and persuasion” (Dimidjian, Barrera Jr, Martell, Munoz & Lewinsohn, 2011, p. 4).

Using behavioural activation techniques in an individualised plan to improve mood and well-being can support the restoration of hope, self-determinism and self-reported health improvements (Cook, Copeland, Hamilton, Jonikas, Razzano, Floyd,...& Grey, 2015). Research into the beneficial outcomes of recovery-orientated tools such as wellness planning are well documented (see, for examples, Salyers, Godfrey, McGuire, Gearhart, Rollins, & Boyle, 2009; Slade, 2010; Warner 2010; Williams, Deane, Oades, Crowe, Ciarrochi, & Andresen, 2016).

From a Foucauldian perspective, wellness planning tools that support the regulation of behaviours for productive purposes function as a technique of disciplinary power on the individual as a subject. Foucault (1975/1984d) noted that docility, (compliance with norms), implies “an uninterrupted, constant coercion, supervising the processes of the activity rather than its result, and it is exercised according to a codification that partitions as closely as possible time, space, movement” (p.181). Wellness planning is one example that creates an environment where the subject is taught to constantly self-monitor their routines, behaviours, and moods. Internal supervision and external monitoring are demonstrated through the WRAP (Copeland, 2002), for example:

If these symptoms come up I need to do all of the following:

- call my doctor or other health care professional; ask for and follow his/her instructions
- call and talk as long as I need to my supporters
- arrange for someone to stay with me around the clock until my symptoms subside
- take action so I cannot hurt myself if my symptoms get worse, such as give my medications, check book, credit cards and car keys to a previously designated friend for safe keeping
- make sure I am doing everything on my daily check list (p. 138)

Wellness planning generally avoids positioning the individual as a subject through diagnostic and illness terminology (Cook, et al, 2015), and instead uses vulnerability and resiliency language in a framework that aims to diminish the attributes of the individual considered maladaptive or unproductive (Randal, Stewart, Proverbs, Lampshire, Symes, & Hamer, 2009). Within recovery discourse, resiliency is used as a technique to encourage the service user to develop self-help behaviours based on learning strategies and skills to deal with distressing symptoms. Maladaptive behaviours such as self-harming are discouraged.

Wellness planning can be seen as a technique of power; in that it increases the power of the subject engaged in the process through emphasis on productivity, yet also decreases the power of the subject through submission to the ideology of norms

represented as health (Foucault, 1963/1989; Foucault, 1975/1984d). By using the strategies and tools suggested in wellness planning, the service user can develop a knowledge of mental illness and recovery that can lead to greater levels of self-determinism regarding interventions, and therefore increase a sense of autonomy. The technique of wellness planning can thereby increase the power of the service user through recovery discourse. However, from a Foucauldian perspective, wellness planning represents and promotes the current political norms and aims of the government, as shown here in the following example taken from the document 'Rising to the Challenge' (Ministry of Health, 2012). Promoting physical health, DHBs are requested

[T]o protect and improve the physical health and wellbeing of people... and to promote healthy lifestyles. This work will include a particular focus on improving the health of people prescribed medications that cause adverse physical health and/or problematic side-effects, such as excessive weight gain (p. 26).

The philosophy behind wellness planning resembles the neo-liberal belief of government deregulation in service provision to increase self-responsibility and self-management by augmenting "people's ability to manage their own wellness by refocusing staff time and providing all staff with recognised training in encouraging and supporting people to develop and use their own wellness plans" (Ministry of Health, 2012, p. 26). Surveillance through service user self-monitoring can be reinforced by monitoring from family/whanau, the service community, such as general practitioners and emergency services.

Formal mechanisms that measure the stages of recovery experienced by a service user can provide a further layer of surveillance. By the beginning of the 21st century the importance of evidence-based practice (EBP), originating from medicine, was being recognised to inform policy and healthcare planning strategies. Anthony, Rogers and Farkas (2003) describe EBP as:

an approach to classifying health care outcome research according to the quality and quantity of empirical evidence supporting a particular intervention. All approaches to classifying evidence-based practices (EBP) rely upon a

hierarchy suggesting what constitutes the most potent and unequivocal evidence that an intervention has demonstrated effectiveness or efficacy (p. 103).

To determine the efficacy of mental health service interventions, in a climate of system accountability, formal mechanisms including the 'Stages of Recovery Instrument' (STORI) (Andresen, Caputi, & Oades, 2006), and 'The Recovery Assessment Scale' (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) attempt to empirically measure a mentally ill persons' journey through the process of recovery. For example, the STORI denotes four key processes to achieve recovery relating to the concepts of hope, positive identity, meaning and responsibility, derived from personal narratives. Five subscales of change are categorised to signify the stages of recovery from illness to wellness within the four recovery concepts, as detailed by Andresen, Caputi, & Oades, (2006):

1. Moratorium: A time of withdrawal characterized by a profound sense of loss and hopelessness.
2. Awareness: Realization that all is not lost, and that a fulfilling life is possible.
3. Preparation: Taking stock of strengths and weaknesses regarding recovery, and starting to work on developing recovery skills.
4. Rebuilding: Actively working towards a positive identity, setting meaningful goals and taking control of one's life.
5. Growth: Living a full and meaningful life, characterized by self-management of the illness, resilience and a positive sense of self. (p. 9732)

The significance of measurement scales from the perspective of individual service user narratives is questionable. Validity for STORI is claimed through positivist scientific correlation with other measurement scales derived from qualitative studies. Results can be ambiguous and potentially meaningless for service users; for example, cluster analysis of STORI items "produced only three stage-related clusters rather than five. This could indicate either of two things: recovery takes place in only three stages rather than five; or, there are five stages to recovery" (Andresen,

Caputi, & Oades, p. 978). Outcome measurement scales using predetermined categories fail to acknowledge the personal experience and meanings derived from mental illness and recovery (Lakeman, 2004):

Little is gained by reducing a person's story to a... ordinal scale ...The meaning, richness and potential are removed leaving a decontextualized impersonal skeleton that cannot do any justice to the art let alone be described as objective (p. 213).

Categorisation of a person with mental illness using a recovery model that examines, describes, measures and evaluates signifies a reduction of the importance of the individual experience (Lakeman, 2004), which could be construed as a contemporary form of objectification. Techniques of objectification were strongly resisted by the service user movement in the 1980s (Deegan, 1987; Leete, 1989). Deegan's (1987) concern that equating a person with an illness is a dehumanising process could be reframed to suggest that a person equated with a stage of recovery, for example, in the STORI (Andresen, Caputi, & Oades, 2006), has the potential to "take on what is called a "master status" in terms of identity" (Deegan, 1987, p. 12), especially for persons who may be categorised as suspended in the initial stages of recovery.

Formal measurements of recovery may support cultural change in services to shift from treatment to recovery approaches based on the evidence-base of specific interventions (Weeks, Sale & Hayward, 2011). Statistics relating to service user outcomes can be used to monitor the quality of service provision, in comparison to the outcomes and costs of other health clinicians or service providers (Shanks, Williams, Leamy, Bird, Boutillier & Slade, 2013). Accountability regarding the quality of service provision in an environment of financial restraint is a mechanism that promotes clinical self-monitoring of professional conduct, where the timely and successful recovery of service users can be used to evaluate professional competence and proficiency (Wong, 2004).

However, measurement tools may also be limited. They may fail to highlight the impact of socio-environmental factors on service user recovery; for example, discrimination experienced by persons with mental illness that delays movement

within empirically based stages of recovery (Andresen, Caputi & Oades, (2006). Measurement tools may also compromise the individuality of the experience as noted by Onken, Dumont, Ridgway, Dornan, and Ralph (2000),

part of the paradoxical nature of recovery is that people... have very divergent experiences and opinions. What helps one person at one time and place to move forward on his or her recovery journey is not important to another person, or can even hold someone back. (p. 75).

Recovery, initially introduced by the service user movement as a process, has shifted in the past quarter of a century to a guiding approach and conceptual model for the delivery of New Zealand mental health services. From a Foucauldian perspective recovery has been used as both an effect of power and an instrument of power. As an effect, recovery has produced new positions in which persons with mental illness can resist psychiatric discourse and claim expertise in the field of madness. As an instrument, recovery has been used to strengthen the concept of resiliency, which situates the problem of illness within the individual.

In the concluding chapter, the complex forces that supported the emergence of recovery as a discursive practice are noted via a number of enduring historical conditions unmasked by this genealogy. The potential for oppression arising from the use of recovery as a service approach is discussed alongside the limitations of this thesis and the possibilities for future research.

Chapter 9: Forces of Power and the Endurance of Knowledge

This thesis has investigated one perspective of how recovery emerged to become the prevalent discourse guiding the provision of New Zealand's mental health services in the 21st century. A genealogical exploration was used to critique the underlying norms and assumptions about the different roles performed by discourses, including recovery, in meeting the needs of specific groups.

In this thesis, the questioning of historical events has disputed the emergence of recovery as a singular linear event; rather, the research has identified a number of forces that have contributed to its emergence, and “the struggle these forces wage against each other or against adverse circumstances, and the attempt to avoid degeneration and regain strength by dividing these forces against themselves” (Foucault, 1977/1984a, pp. 83-84). This closing chapter concludes the thesis with a final analysis of some of the forces that have assisted recovery's emergence, and how recovery has been used to shape the current behaviours of providers and users of mental health services. The chapter identifies aspects of enduring historical knowledge in current discursive practices that contribute to the representation of persons with mental illness and which may act as barriers to their acceptance and inclusion in New Zealand society.

Recovery in contemporary New Zealand mental health practice is a byword for the provision of clinical interventions that are aimed to empower service users on their mental health journey. Taking direction from current policy (see 'Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 (Ministry of Health, 2012); 'New Zealand Health Strategy: Future direction (Minister of Health, 2016), as examples), mental health services are directed to support service users to make informed choices that increase their resiliency, productivity and inclusion in society.

The recovery approach represents a force for the current users of mental health services to access power as consumers of services within an environment that

promotes their empowerment and self-determinism. Recovery discourse also constrains the power of service users by shaping new subjectivities that concur with political ideology. It shapes subjectivities by embodying the aspirations associated with the service user movement in conjunction with the health norms associated with recovering. Representing self-determinism and autonomy as essential conditions to enable good health, the current political use of recovery in policy to shape behaviour curtails resistance to health norms, by representing health/recovery knowledge as a truth. For example, policy, such as in 'Rising to the Challenge', (2012), notes that the culture of recovery, developed as a process, aims to support people to reach their full potential in life. Behaviours that are represented as enabling wellness, such as abstinence from drug use and engagement with productive roles act to normalise specific values and knowledge, thereby manipulating subjects' behaviours to suit neo-liberal ideology.

The internalisation of norms promoted by government to increase the knowledge and power of service users can create intelligible subjects who then seek freedom from an abject psychiatric representation. One way to attain freedom from a psychiatric label is for a person to naturalise the social and medical role expectations placed on them through the constitution of the self (Foucault, 1963/1989; Roach Anleu, 2006). The concept of health literacy (Minister of Health, 2016) is a contemporary example of bio-power, which aims to create intelligible subjects through education, shaping a persons' understanding of healthy lifestyles that are habitually internalised into their routines and priorities. Techniques such as wellness planning specifically target symptoms, experiences and behaviours to achieve this end.

Individual responsibility for maintaining good health following or during adversity is now part of health literacy, through the concept of resiliency. Although a relatively new term ascribed to the recovery approach, resiliency represents an enduring historical knowledge favourable to psychiatric discourse and the ideology of neoliberalism, by positioning the problem of madness, or inability to cope with distress caused by madness, as an internal fault within the subject. Historically, positioning the problem within the subject enabled psychiatry to act as a force on the patient through confinement and medical and moral treatments. The current influence of neo-liberalism in the arena of mental health situates the problem and the

solution, and thereby the responsibility, within the subject. If the choices and behaviours made by subjects concur with current social values, then the subject is encouraged to take greater responsibility. If the choices and judgements, contextual to the problems or solutions, made by the service users are assessed as irrational and uninformed, the subject can be objectified through the removal of responsibility, and labelled as problematic.

Concurring with the personal narratives of persons associated with the service user movement (see Lampshire in Attitude Live, 2015; Coleman, 2016, as examples), positioning the solution for recovery as coming from within the subject, shifts power from psychiatry to the person diagnosed with mental illness. However, as demonstrated in tools designed to support recovery, such as wellness planning, the absence of resiliency enables external interventions that can manipulate the behaviours of the subject towards norms (Furedi, 2008) of dominant health discourse, shifting power back towards services. Unlike the force of earlier psychiatric practices, service users may be less resistive to interventions, as the recommended behavioural changes appear to pertain to the desires and goals of the subject.

Situating the problem and solution within the subject through the concept of resiliency can be highly advantageous to the subject who grasps this notion and engages in a recovery journey that corresponds with service values. However, resiliency has the potential to draw attention away from the socio-political and environmental conditions that may lead to illness. As a concept, resiliency may be meaningless for populations caught in a cycle of deprivation, poverty and abuse. Within current education and research, social justice issues, as previously raised by the service user movement and the anti-psychiatry movement, need to remain on the political agenda.

One objective of resiliency relates to the encouragement of persons with mental illness to develop strategies that increase their productivity, through social and/or work roles. During the Enlightenment period, one approach used by physicians to engender the abject identity associated with madness, was the determination that the patient was unable to engage in productive roles. Persons who, for whatever

reason, lacked the capacity to be productive, were depicted by authority as irrational and immoral and were dehumanised through objectification. The medicalisation of unproductive subjects enabled their objectification through their representation as 'ill' and their abnormality was confirmed by a selective gaze highlighting negative and problematic behaviours (Goffman, 1959).

The concept of productivity was also found in 'The Community Mental Hospital: Third Report of the Expert Committee on Mental Health' (WHO, 1953), which noted the lack of productivity as a barrier to social inclusion for ex-patients on leaving the hospital. Useful activities were encouraged in psychiatric hospitals to support the patients' engagement in practices that replicated citizenship. Productivity was also promoted in the report as a way to shape behaviours, thus minimising resistance, by encouraging patients to identify needs and generate solutions. It was used as a strategy to help patients to cope with the intolerable conditions of the hospital.

Productivity is a concept attached to recovery that has been driven by the users and providers of mental health services. Personal narratives from persons with mental illness in the 1980s criticised their passivity in mental health service delivery and planning. Passivity was realised as a consequence of the invisibility and silence imposed on service users (O' Hagan, 2014). Anthony's (1993) seminal document 'Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s' stated a need for persons with mental illness to experience a "contributing life even with limitations caused by illness" (p. 15) within the definition of recovery. Productivity was venerated in early policy, as in, 'Moving Forward: The National Health Plan for More and Better Services' (Ministry of Health, 1994) which inspired services to encourage individuals to "fully participate in society" (p. 5). Gaining a valued place in a community was noted in 'Te Tahuhu: Improving Mental Health 2005-2015' (Ministry of Health, 2005) as concomitant with productivity. Work productivity was also highlighted in 'Blue Print II: Improving Mental Health and Wellbeing for all New Zealanders, How Things Need to Be' (Mental Health Commission, 2012), as a protective factor that could provide a sense of citizenship and equality.

Productivity is highlighted as an enduring historical knowledge, normalised in contemporary policy, which supports social inclusion and a sense of citizenship for persons previously segregated and stigmatised. For many who experience significant illness, a return to productive social and work roles may support and signify a return to wellness. However, the correlation between productivity and the concept of rationality, or its modern term of wellness, can act as a force to stigmatise and segregate persons with mental illness who, for whatever reason, are unable to participate in roles that are currently represented as productive. With neo-liberal attitudes increasingly emphasising the financial contribution of subjects as a definition of citizenship, specific sub-populations of the mentally ill who are unable to attain socially accepted productive roles are at risk of further discrimination and dehumanisation. A challenge for service providers who support those unable to engage in productive roles within the recovery approach, as defined by services, is to explore new perspectives of knowledge that appreciate the value of madness in forms that exclude neo-liberal productive values.

The ability for people with mental illness to be accepted and included in society is observed in this thesis as an enduring aim of service providers and service users, dating back to the Enlightenment period and emphasised in the 'Community Mental Hospital: Third Report of the Expert Committee on Mental Health' (WHO, 1953). Current concerns regarding social inclusion focus on tackling the stigmatisation and discrimination of madness, which is entrenched in society. A major force that significantly cements a highly negative perspective of madness comes from the media, which correlate mental illness with dangerousness. Apart from the generation of fear, which can act as a barrier to social inclusion, media can also reinforce the medicalisation of human experiences and emotions that have little cultural value, and which are often characterised as negative, such as anger, sadness, shame and guilt (Williams, 2016).

The terminology and representation of madness has been recorded by people involved with the service user movement (Chamberlin, 1990; Deegan, 1987) and other advocates, including the 'Mental Health Advocacy Coalition', as a major barrier to social inclusion. Diagnostic terms, such as Paranoid Schizophrenia, have been critiqued as dehumanising and thus limiting potential. Diagnostic terms remain

forefront in the medical perspective of madness, which shares an uneasy collaboration with the recovery approach in service provision. Changes to terminology through recovery discourse may have acted to promote the destigmatisation of the mentally ill population, for example by representing illness as distress. Distress and vulnerability language may reduce the self-stigma and service stigma persons with a mental illness may experience. However, changes to terminology also enables the targeting of broader populations who experience levels of distress beyond socially acceptable norms, creating new diagnostic labelling for subjects by further blurring the boundaries between normality and abnormality (Widiger & Clark, 2000).

To support the social inclusion of persons with mental illness, acknowledgement of the diverse needs of specific populations, such as Maori, is referenced in policy. 'He Korowai Oranga: Maori Health Strategy' (Ministry of Health, 2002) wrote that for the successful implementation of policy, interventions require the incorporation of Maori perspectives of health and illness knowledge. Regulating the behaviours of persons through interventions that suit their ethnicity is not a new phenomenon. Pinel noted in 1806 that the moral treatments used to enable rationality differed for persons based on their ethnicity and class. Recovery discourse has been noted in this thesis to complement the concept of Maori self-determinism in the arena of health provision by promoting the use of models such as Whare Tapa Wha. However, the neo-liberal perspective regarding individual responsibility for illness, including the problem and solution, creates tension with a collectivistic Maori worldview. A concern raised in this thesis relates to the potential tokenism of Maori perspectives in current policy, especially contextual to the concept of resiliency. Without a focus on collective needs and solutions for health care, through awareness of the impact of colonisation and by tackling underlying socio-political causes of illness for Maori, contemporary political discourse may further stigmatise and dehumanise Maori service users who are assessed as non-compliant from a Western perspective.

Recovery discourse in the 21st century has been used by services as an attempt to measure the progress of change for service users during their wellness journey. For

some service users it may be helpful to note internal changes that can promote further recovery. As a concept, however, it is argued in this thesis as authorising the objectification of subjects through their representation as a recovery stage. Current classification systems may use terminology that avoid objectification on the scale that diagnosis has historically achieved; however, there is a danger that the greater use of empirical measurement scales and the development of new language sympathetic to neo-liberal ideology, may aid more covert forms of objectification, as well as creating new opportunities for surveillance.

Prior to recovery's adoption by mental health services users to empower and shape the behaviours of service users, this thesis unmasked the use of recovery discourse to support the internalisation of neo-liberal ideology and new forms of surveillance in the mental health workforce. Neo-liberal values have shifted the surveillance of clinicians from managers to the clinician and their peers through a number of strategies, including self-directed learning, supervision and peer review, which enable the internalisation of practice norms. A further layer of surveillance has been developed through the empowerment of service users who are encouraged to give feedback according to their rights as users of health services. With the majority of care occurring in the community, family and whanau are also better able to critique the behaviours of the clinician and the service in general. Surveillance is identified as a technique to tackle the stigmatisation of and discrimination against persons with mental illness that occurs within the mental health workforce. However, it can also constrain the independence of the clinician by restricting practices that fall outside of neo-liberal ideology.

Recovery has also been used to shape the behaviours of the mental health workforce through the promotion of a discourse that is seen to empower and increase the responsibility of service users. The increasing representation of service users as more knowledgeable and autonomous, with greater access to power, not only shifts power away from the providers of services but also supports the ethos of cost cutting and reduced resources. Wellness planning is an example of how cost cutting is achieved, as service users become their own 'therapists' with support from family and local community. Further deregulation of services may enable new populations to access mental health support through community organisations.

However, in the process of shifting interventions away from secondary health care providers, some vulnerable persons may not be able to access an appropriate level of support, as those supporting them may not have adequate clinical knowledge to respond to behaviours indicative of significant risk.

The purpose of this thesis relates to the unmasking and critiquing of common assumptions that infringe on mental health practices, including those of my own in my current role in a crisis mental health response team. I now have greater awareness of the knowledge/power I can access, which shapes the behaviours of others, through the concepts of health literacy, resiliency, and recovery and which are currently represented in policy as contemporary norms of clinical practice. Within my role I am able to facilitate persons to access power through recovery-orientated interventions but I am now better able to critique aspects of my practice which inhibit personal freedom masked as recovery. The thesis journey has increased my awareness of knowledge discourse presented as liberating, yet which acts to discipline behaviours to meet the needs of a society that values neo-liberalism (Crowley, 2009; Foucault, 1977/1975) and thereby, are covert forces of oppression.

Portraying just one perspective of how recovery emerged to play a dominant role is a limitation of this thesis, as other perspectives would offer other possibilities. The material selected to support these findings can be viewed as another limitation, in relation to the selection process and the possibility of missing data, especially from more empirical positions.

Recovery, in the context of this thesis, has been critiqued as a technique of power that has been shaped by forces to meet the needs of specific groups and shape the behaviours of other groups. Resiliency, productivity and social inclusion have been identified as major contemporary conditions derived from enduring historical knowledge that represents the recovery approach in 21st century New Zealand mental health practice. Recovery, described as a process, has supported major changes to mental health service provision enabling persons with mental illness to

have greater access to power. The co-opted discourse of recovery as a service approach has also created new opportunities to govern subjects and populations with less resistance, through the relationship of liberty and discipline (Foucault, 1977/1975).

Concluding statement

Recovery is critiqued in this thesis as problematic in the ways that subject positions are endorsed and excluded by the discourse. Since the turn of this century, recovery in New Zealand has been increasingly structured and measured by service users, advocacy groups and providers to represent new subjectivities for persons with mental illness. The discourse endorses subjects who define the self from a qualified position through observance of the components, such as social inclusion and productivity, which define recovery. Shaped by neoliberal values, the concepts of autonomy, responsibility and resiliency can endorse persons with mental illness as subjects regaining and maintaining reason. As an exclusionary discourse, recovery can define subjects who are unable to engage with the components of the recovery journey, for whatever reason, as problematic. Persons who engage in behaviours perceived by service providers as maintaining or fostering madness, such as noncompliance with prescribed medications, are at risk of negative labelling, and thereby social exclusion. Those who do not engage in self-surveillance strategies to monitor health and symptomology can be defined from a clinical position as lacking insight and thereby perceived as lacking the ability to make informed decisions.

In contemporary New Zealand mental health service provision, recovery is presented as an adaptive response to mental illness that fits well with the present-day neoliberal values of health literacy and personal responsibility. Within New Zealand policy, recovery discourse emerged as a philosophy to critique and improve the provision and quality of mental health services to benefit persons with mental illness. Through internalising the key concepts of recovery, the mental health workforce shaped an empowering model of care. Clinical governance strategies, such as supervision, established panoptic measurements of accountability that incorporated the self-regulation of clinical conduct. Within the last decade, emphasis in policy

shifted from the providers to the users of mental health services through the promotion of self-responsibility and self-management of wellness. Introduced as a concept linked with recovery, the concept of resiliency promoted adaptive methods of functioning based on strengths rather than a focus on the illness. Resiliency supported a shift of culpability from services onto persons with mental illness through defining the skills and strategies needed to support wellness, along with the expectation that subjects would fully participate within health literacy. Personal responsibility, resiliency and autonomy are core values of neoliberalism and are associated with citizenship and social inclusion. Persons who struggle or fail to engage with the neoliberal values concurrent with recovery discourse are at risk of being labelled as maladaptive, thereby incapable to make informed decisions, and are at risk of compulsory treatments.

Recovery discourse, based on neoliberal values, has shifted power away from some persons with mental illness, as it no longer plays a major role in critiquing service provision and general attitudes regarding mental illness. Instead, through representation as an outcome measurement tool, recovery can be used to critique the lifestyle and responsibility of the subject against standards informed by current health norms. Measuring subjects against health standards compromises the key concept of the individuality of the recovery experience. The focus on subjects also shifts the gaze away from the socio-economic factors that contribute to mental illness and which potentially constrain subjects from low socio-economic backgrounds within the overarching discourse. By working as a force that can be both inclusionary and exclusionary, recovery may contribute to the enduring historical beliefs from the Enlightenment that certain subjects are irrational and subhuman, as they unable to engage in the journey.

For social change, it could be argued that a multiplicity of discourses in mental health service provision may better represent subjects excluded by recovery discourse. However, it could also be argued that there is little fundamentally wrong with the philosophy of recovery, as demonstrated by subjects that benefit from the approach in New Zealand's mental health care systems. For social change, it is argued in this thesis that specific populations that are excluded by the discourse are incorporated into research to identify, and later support to challenge, specific socio-economic

factors that hinder subjects to live meaningful and satisfying lives with or without the symptoms associated with mental illness.

[I]t is not our job to pass judgment on who will and will not recover from mental illness and the spirit breaking effects of poverty, stigma, dehumanization, degradation and learned helplessness. Rather, our job is to participate in a conspiracy of hope

(Deegan, 1987, p. 8).

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