Becoming response-able to the entwined crises of 'domestic violence' and 'mental health': An experience of joy with Gandhi Nivas

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Arts

in

Psychology

at Massey University, Manawatū, New Zealand.

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2022

Abstract

This project commits to becoming response-able (Haraway, 2016) through an increase in understanding experienced as joy (Braidotti, 2019a) when responding to the entwined crises of 'mental health' and 'domestic violence'. Beginning with a memory of being un-able to respond ethically when located within system-responses that privilege a particular form of expertise, the project locates the privileged form of expertise as situated knowledge (Haraway, 1988) that offers a limited and partial perspective and hence the need to *think with* an-other. Moving to connect with an-other (the creative community collaboration of Gandhi Nivas responding ethically to the problem of domestic violence) and understanding thinking as a relational activity (Braidotti, 2019a) enables *a different voice* of expertise privileging *care* to be heard in the recognition of the multiplicity of difference and an other-wise telling of our beginning memory. *Thinking with* the multiplicity of difference and the experience of those who have not gained powers of discursive representation also enables an increase in understanding of the social power relations that resist acknowledging the partiality and connections made possible by situated knowledges. The social power relations instead code a multiplicity of differences through a binary and the knotted relationships of patriarchy, colonisation, imperialism and advanced cognitive capitalism. This project argues for the fundamental necessity of recognising caring expertise and other-wise knowledges situated elsewhere to become response-able as communities for the entwined crises of 'domestic violence' and 'mental health'.

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CHAPTER ONE: *An* Introduction

Adequate understanding provides the subjects with an increase in their power to act, which is experienced as joy and the renewed desire to go on knowing more and better (Braidotti, 2019a, p.131).

Why tell stories like this, when there are only more and more openings and no bottom lines? Because there are quite definite response-abilities that are strengthened in such stories (Haraway, 2016, p. 115).

This is a project of endurance dedicated to adequate understanding (Braidotti, 2019a) and strengthening response-ability - the ability to respond, ethically (Haraway, 2016). It is a project of feminist objectivity and situated knowledge from a particular location and recognises knowledge claims and one's vision/vantage point as always necessarily partial, selective, and incomplete (Braidotti, 2019a; Haraway, 1988, Harding, 1986). In recognising the partial and selective character of knowledge claims and vision, thinking becomes a relational activity (Braidotti, 2019a) where one seeks openings and interconnections to learn to think with an-other to increase adequacy of understanding and response-ability. From here, thinking always involves a 'we', rather than something that can be done as an individual, and Braidotti (2019a) suggests that we should always begin by questioning who 'we' might be. Thinking then, as well as becoming a relational activity, becomes a nomadic process *"which takes place in the transitions between potentially contradictory positions"* (Braidotti, 2006a, p.199). To account for who 'we' might be in this particular project, to make sense of the transitions between contradictions, and to trace the present nomadic journey as a relational activity, in the pages that unfold I offer a cartography of figures becoming within the domestic violence field and the interstices of their relationships with psy-disciplines and psy-expertise. As becoming figures meet at an intersection of crises of 'domestic violence' and 'mental health', a cartography becomes a *"theoretically-based and politically informed reading of the present"* (Braidotti, 2010, pp. 409-410) that traces connections, figures and spaces to follow the flows of social power relations and to recognise power as both restrictive

(potestas) and empowering (potentia) (Braidotti, 2019a). By addressing the social power relations through thinking with, working with and speaking with people whose knowledge has not gained powers of discursive representation, I seek an adequate understanding of "*what 'we' are ceasing to be, as well as what 'we' are in the process of becoming*" (Braidotti, 2019b, p.37), recognising possible forms of creativity and transformation enabled by affirmative ethical relations (Braidotti, 2008). I seek to increase our ability to respond, ethically; I trace a cartography of figures becoming response-able (Haraway, 2016) and experiencing joy[1] (Braidotti, 2019a) in the work of addressing the intersection of the crises of 'domestic violence' and 'mental health'.

I begin then with a memory, where 'I' am not an 'I', but already a 'we'. For Braidotti (2006a, p.199) *"a location is an embedded and embodied memory"*, always interrelational and collective. Becoming with Braidotti permits the remembering of a day with April[2]. Though I hesitate in bringing April onto these pages, I am encouraged to do so as Braidotti (2010) reminds me that to remember the pain and injustice I felt with April is a way of *"bearing witness to the missing people – to those who never managed to gain powers of discursive representation"* (p.414). It is not a 'choice' to bring April into this story, it is an ethical response -ability given my privileged location within the psychology discipline, a field of research and practice that has gained powers of discursive representation. Bearing witness to April, we begin on a day when understandings pertaining to 'mental health' and 'domestic violence' were inadequate, dis-abling possible (ethical) responses.

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[1] Particular ideas will recur throughout this cartography, including two introduced here: response-ability (Haraway, 2016) and adequate understanding experienced as joy (Braidotti, 2019a). I consider these ideas I use often as word gifts from the authors, connecting to Geneva Connor's (2019) doctoral thesis where she accepted similar word gifts and *"referenced without referencing, connecting text with text"* (p.4). In doing so I am becoming response-able to the authors and welcome their voices as guides in nomadic movement.

[2] Name changed to protect privacy

We begin then, on a day I remember with April….

I met April several years ago in my local police station. I was there in a volunteer capacity to support 'victims' of crime, and April was categorised as such that day. I sat with her in the foyer of the station as she (we) waited for her partner who was currently in the cells, awaiting a mental health assessment from the crisis team. April was covered in blood and bruises which she continued to reassure me, and the concerned police officers, were *"nothing"*. She recounted to me her story of 'what had happened' earlier that morning; how her partner had woken up, turned to April and told her he was going to take his life that day. This was not an uncommon experience for April; her partner was categorised as 'having' bipolar disorder, and she had developed skills in responding to what she described to me as *"his mental health crises"*. She supported her partner, listened to him as he spoke, and when she realised the situation was beyond her supportive capacity, she called the mental health crisis team as she'd been instructed to do previously by her partner's community care team. The crisis team had informed April that they were stretched to capacity but would be there as soon as possible, telling her to *"keep him in the house"* and to *"keep him safe"*, hanging up the phone. With the responsibility for both her and her partner's safety returned to April, she had paused to consider what to do next, but by that stage her partner had heard the phone call, assumed the crisis team was coming and was gearing up to leave the house. Panicked, April stood in front of the doorway to prevent him leaving (as instructed) but he used physical force to get past her. April followed him, begging him to stay, and in response she received more pain. Her partner left, April called the police as she was concerned for his safety, and they were (eventually) brought to the station.

As April told me her story, one of the police officers interrupted us.

"Please, you need to consider laying a 'male assaults female charge' against him," the officer begged. *"I've seen bruises like these before..."*

"No no no, he's no criminal!" April cried. *"He needs help! The crisis team are here and they are assessing him, they'll see he has a mental health history and that what he needs right now is psychological support."*

The officer looked at me, and then back at April.

"I understand, I understand that he's unwell. But he's still hurt you. And what if the crisis team don't section him and they release him back to you? Please, please consider it. The last woman I saw with bruises like this –," he gently cradled her arms, blotted with fresh blue and green bruises. *"Well, the last woman I saw with bruises like this, she didn't lay a charge. She didn't get a protection order. And two weeks later we were burying her."*

I locked eyes with the officer and saw the fear, care and determination in his eyes.

"I won't, I won't do it. He doesn't deserve a criminal record. He deserves help," April maintained.

The officer sighed, suggested she *"think about it"* and left us to it.

The mental health team didn't section April's partner that day. They decided that the 'crisis' was one of a *"domestic violence issue"* and not that of mental health. Here, the response system I was part of made a clear delineation; if it was not a mental health crisis but a domestic one, it became the territory of police, and me, rather than psychologists and psychiatrists. April had denied the help of the police, as they could only offer her legislative instruments that would criminalise her partner for his actions.

The responsibility of service provision (and safety) was left with me. I talked April through a safety plan that seemed redundant in these circumstances, given it was a plan for April to leave her partner during his crisis. April had made it clear that would not happen. I reminded her of the crisis team, which seemed similarly problematic given what had ensued that day. What I had left was to stay with April, to hear her, to care for her, and to acknowledge her experience that the system could not see. But as my space of response-ability remained in the police station, I had to (eventually) return the responsibility for safety (both her and her partner's) to April.

As April and her partner left the police station that day, I was troubled. I worried about April, I worried about her partner. I wondered if April or her partner would become 'just another statistic' in domestic violence or suicide reporting, and I worried about my complicity as a service provider if that were to be the case.

I was as troubled then as I am now in remembering April. It is through remembering April and bearing witness to her that I vow to *"stay with the trouble[3]"* (Haraway, 2016, p.1) of her experience that day. Understood through our system of response and discursive representation, her experience could be recognised as **either** a 'mental health' crisis experienced by (only) her partner, **or** a 'domestic violence' crisis, which located April as a 'victim' and (therefore) her partner as a 'perpetrator'. Recognising her experience through an **either/or** lens meant our system was set up to respond to only *one* of the crises *('mental health'* **or** *'domestic violence)*, not both, and definitely not both **at the same time**.

The privilege of staying with the trouble…

Though *staying with the trouble* of April's experience is painful as I remember my dis-ability located within a system response, being able to *stay with the trouble* within the discipline of psychology, a discipline afforded the powers of discursive representation, is a privilege that many do not have (and hence my ethical response-ability to bear witness to April here). The privilege of my education offers me other embedded and embodied memories (locations) that infuse this cartography. I bring the memories shared with psychology students, lecturers, researchers and psychologists – memories I am part of as a member of a psychology student assemblage, and as part of a teaching assemblage in an institution's School of Psychology. These memories are full of enthusiasm, care and passion where 'we' meet to learn how to 'help' people like April and her partner. I am engulfed by the care that flows from these assemblages and I am inspired by it.

However, remembering April and these psychology assemblages, I know that *wanting* to care and help can remain inadequate, and *wanting* is not the same as car*ing* and help*ing*. I also know that as I seek to open spaces for alternative knowledges to learn to think with an-other, I do so within a context of advanced cognitive capitalism that *"profits from the scientific and economic understanding of all that lives"* (Braidotti, 2019b, p.41) and within a discipline that privileges a particular understanding of life: the conditional and exclusionary category of the 'human' built upon hierarchical social power relationships including speciesism, racism, sexism, ableism, classism and more. Braidotti (2010) thinks with Deleuze

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[3] Another word gift from Haraway

and Guattari to make sense of who is included in the category 'human', and she suggests they *"offer the perfect synthesis of this dominant image of the subject as masculine/white/heterosexual/speaking a standard language/property-owning/urbanized"* (p.409). In other words, while feeling the enthusiasm, care and passion when 'we' meet to learn how to 'help' people like April, I hear the critiques of psychology's Eurocentric normalisation, categorisation and measurement processes as complicit with advanced cognitive capitalism through an extension of colonisation (Coombes et al., 2016; Groot et al., 2012; Robertson & Masters-Awatere, 2007; Seedat & Lazarus, 2011; Sonn & Quayle, 2012). These critical insights remind me that the psychology discipline risks inadequate understandings by listening through a frame which is situated, partial and limited, but presented as universal and all-seeing, a technique Haraway (1988) terms *"the god trick"* (p.581). To open space to hear April's story from her location and her vantage point, rather than to listen to it through the frame of the psychology discipline requires (at least) two actions; the first is to locate the current knowledge claims of mental health and domestic violence crises that have the privilege of discursive representation – this is the task of the literature review chapter. Location enables a recognition of limitation, and therefore the need to move, which is our second action; movement to transform the conditions of possibilities for a hearing of *a different voice*, a voice that is located elsewhere and hence offers a different perspective and vantage point to think with and respond. The methodology chapter will detail the processes of movement that enabled a hearing of *a different voice* located in the community of Gandhi Nivas, a collaborative community response to family violence in Aotearoa. Moving to hear *a different voice,* I then retrace the storylines of my day with April through my analysis and reconfigure an otherwise becoming for her and her partner through connections with Gandhi Nivas staff; staff experienced at responding to the meeting of **both** crises - *'mental health'* **and** *'domestic violence'* - **at the same time**.

To be able to hear April (and other 'missing peoples') we need to be open to movement, to becoming nomadic as we think relationally, together. Movement and hearing enable a process of articulation of a more response-able adequacy of understanding:

Adequate to what? Adequate to what the missing peoples – the embodied, embrained, relational, affective subjects as transversal assemblages – can do, in

terms of sustaining intensity, processing negativity and producing affirmation
(Braidotti, 2019b, p. 51).

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CHAPTER TWO: *A* literature review

It matters what thoughts think thoughts. It matters what knowledges know knowledges. It matters what relations relate relations. It matters what worlds world worlds. It matters what stories tell stories (Haraway, 2016, p.35)

We begin (again, here) where power manifests in knowledge claims throughout the literature pertaining to mental health and domestic violence crises, and where it matters *"what thoughts think thoughts"[4]* when seeking to increase response-abilities (Haraway, 2016, p.35). On the day I am remembering with April, her experience was fragmented by our systems of response into **either** a 'mental health crisis' **or** a 'domestic violence crisis', a decision for the psy-experts from the mental health crisis team to make. The *either/or* of the fragmentation troubled me; April had rung the crisis team because she understood her partner was experiencing mental distress and required support which was beyond April's individual capacity – from her perspective, April's partner was experiencing a *mental health crisis* that required support and care from mental health professionals. However, the police officer had noticed the blood and bruises on April's body and was concerned about her safety in the relationship – from his vantage point, he had recognised April as a 'victim' and (therefore) her partner as a 'perpetrator' in a *domestic violence crisis.* As April's partner was released from his mental health assessment with no follow up or support, the *'mental health crisis'* April had rung for help for was deemed not to be happening. Instead, the only avenue available for April required her to take up the location of 'victim' and recognise her partner as a 'perpetrator', locating her experience as only understood through a *domestic violence crisis.* As April had sought *"support"* and *"help"*, not criminalisation of her partner or punishment for his behaviour, April refused to take up the 'victim' location offered to her, despite acknowledging that there were times she felt unsafe and scared in her relationship.

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[4] *"What thoughts think thoughts"* and (soon) *"what knowledges know knowledges"* and *" what stories tell stories"* are more word gifts from Haraway (2016) that appear throughout my cartography

Hence, she and her partner left the police station with no support or assistance in place, and with April's partner furious about *"the mess she had made"*[5].

I remember the distress I felt as the system responses I was part of struggled to hear April's experiences and instead translated and fragmented them into experiences the system could recognise through the discourses of psy-expertise and criminal justice: "victim", "perpetrator", "mentally ill", "domestic violence". I could understand this translation as an attempt to increase our response-abilities as a system, trying to figure out who were the most appropriate people to work with April and her partner, to provide them support and safety through their distress. We were listening to April from our standpoints, our vantage points, and we matched up what we heard, saw and felt with what we were trained for and used to hearing, seeing and feeling. But *"it matters what thoughts think thoughts. It matters what knowledges know knowledges"* (Haraway, 2016, p.35). April's thoughts were different to ours, and what she knew, she knew differently. Though *"translation is always interpretive, critical and partial"* (Haraway, 1988, p.589), we did not recognise the partiality and limitations of the conditional hearing we granted April that day through our own translations. Instead, we (as a system) responded with the *"god trick"* (Haraway, 1988, p. 581), suggesting we could see all and hear all, and offering back to April our system's understanding as the totality of her experience. As April walked out the door, I felt my dis-ability within a system (apparently) built for becoming response-able. I remember this dis-ability and bring it with me into the literature as I seek to locate the literature's knowledge claims about the two crises – mental health **and** domestic violence – as a view from *somewhere* rather than an all-seeing *"god trick"* (Haraway, 1988, p.581). In doing so I (also) seek to trace what response-abilities and dis-abilities these knowledge claims enable for people responding to those at the intersection of the two crises. From here, I recognise the partiality of our system's knowledge claims and therefore open space for different *thoughts that think thoughts* and *knowledges that know knowledges* about the two

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[5] It is worth recognising here that threats of suicide are recognised as a tactic of coercive control and entrapment in domestic violence literature (e.g. Johnson et al., 2019; Robinson et al., 2018) and so could have been recognised by the system responses as a manifestation of a 'domestic violence crisis'. However, the concern remains that April was looking for assistance in providing *"help"* and *"support"* for her partner which was not accessible under a system response to *either* crisis ('mental health' *or* 'domestic violence').

crises, seeking the *"connections and unexpected openings situated knowledges make possible"* (Haraway, 1988, p.590).

I headed into the literature to find April's story with the two crises that the system response had translated her experience into that day: 'mental health' and 'domestic violence'. Typing these two terms into the search bars of PsycINFO, Scopus and Google Scholar during September 2020 and November 2021, I found research focused predominantly on the impact of 'domestic violence' *on* victims' 'mental health' (e.g. Bunston et al., 2017; Ellsberg et al., 2008; Howard et al., 2015; Humphreys & Thiara, 2003; Roberts et al., 1998; Sediri et al., 2020) and I was asked by the algorithms if perhaps I meant 'severe psychiatric disorder' or 'mental illness'. As a curious researcher I took the suggestion and found that though this produced work from different researchers, the focus remained heavily on the impact of violence *on* victims' 'mental illnesses' (e.g. Hegarty, 2011), or whether one's 'mental illness' put them at greater risk for 'victimisation' or 'perpetration' (e.g. Khalifeh et al., 2015; Labrum et al., 2020; Spencer et al., 2019; Yu et al., 2019), seemingly searching for a causal relationship. Intrigued, I wondered what would happen if I used the term 'family violence' instead of 'domestic violence', as although 'domestic violence' had been the words used by the crisis team and the police on my day with April, 'family violence' is the term used in Aotearoa's policies and laws (e.g. Family Violence Act, 2018)[6]. Coupling together 'family violence' with either 'mental health' or 'mental illness' produced research that either reproduced the same search for a causal link (how family violence *impacts* one's mental health/mental illness) or inverted the search for the causal relationship between the two crises with a focus on how 'mental health/illness' is linked to perpetration of 'family violence' (e.g. Kageyama et al., 2015; Oram et al., 2014; Solomon et al., 2005; Vaddadi et al., 2002). Regardless of which terms I used, the dominant narrative remained the same: these were two separate (although linked) crises, experienced by individuals, with one crisis preceding the other.

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[6] In Aotearoa New Zealand the Family Violence Act 2018 has replaced the Domestic Violence Act 1995. On my day I am remembering with April, 'domestic violence' was the term legitimated by system responses. Changes were made to recognise the legal definition of 'domestic violence' did not *"reflect a modern understanding of family violence as an ongoing pattern of control that can take many different forms. This can lead to inconsistent decisions about who the Act protects, and in what circumstances"* (Ministry of Justice, 2016, p.8). Replacing 'domestic violence' with 'family violence' was intended to reflect said *modern understanding*. However, notably both of these terms do not attend to the patriarchal gendered social structure that underpins manifestations of domestic or family violence (Mikaere, 1999; Tolmie, 2018).

The hyperintensive focus on individuals…

With a focus on mental *health* or mental *illness,* experiences of mental *distress* are reproduced as experiences of *illnesses* through the language of *"neurobiologically deficient"* subjects that require *treatment* from medical and mental health professionals such as psychiatrists and psychologists (Walker et al., 2015, p. 504). While attention is also paid to *"'the environment' as a provoking or protective factor",* a focus on pathology and abnormality in an individual through diagnoses of mental disorders legitimates individual level responses such as psychiatric pharmaceuticals and talk therapy in an attempt to restore 'normalcy' (Rose, 2019, p.54). Keeping understandings of mental distress at the individual level with a focus on (ab)normalcy through psy-discourse means the unequal social power relations that operate as the key determinants of health remain unacknowledged (Hodgetts & Stotle, 2017). Concerningly, the individualisation of these issues ignores knowledge produced since (at least) the 19th century that demonstrates:

> *it is now beyond doubt that these social conditions – not just inadequate diet, polluted water and bad sanitation, but also poverty, unemployment, social isolation, insecurity, inequalities in status, power and control – affect mental health as much as physical health (Rose, 2019, p.50).*

These concerns have been recently echoed in Aotearoa by *He Ara Oranga – The Governmental Inquiry into Mental Health and Addiction* that emphasised the importance of recognising an individual in context and turning attention to the social determinants of health when considering both the prevention of and response to 'mental illness and addiction' (Patterson et al., 2018).

Similarly, the dominant understandings of 'domestic violence' individualise experiences through discourses of criminalisation with a focus on discrete acts of physical violence that produce individual 'victims' and 'offenders' (Stark, 2012). The 'evidence' of the discrete act of physical violence was what the police officers and I saw on our day with April – the blood and bruises on her body that suggested April was a 'victim' and (therefore) her partner was an 'offender' (or 'perpetrator'). However, the focus on the physical violence as a particular *event* detracts attention from the patterns of coercive control and social entrapment – the conditions of everyday lives – that enable manifestations of discrete violent acts (Morgan et al.,

2019; Stark, 2012; Tolmie, 2018). Here in Aotearoa, the New Zealand Family Violence Death Review Committee (NZFVDRC) reports continue to acknowledge the imposition of colonial gender norms and roles under a patriarchal social structure as a vital contributor to our high rates of domestic violence (2016; 2020; Short et al., 2019), and Mikaere (1999) teaches me that the remoulding of Aotearoa's indigenous society through imposition of patriarchal gender norms was (is) the most dangerous aspect of colonisation. Yet through a culturally specific knowledge system focusing on individual events and (gender neutral) categories ('victim', 'perpetrator', 'mentally ill'), the social entrapment of the patriarchal structure is not attended to as a key space for intervention. Furthermore, these gender-neutral categories are exclusionary and understood as mutually exclusive with the boundaries limiting whose experiences of violence are recognised as legitimate; the 'ideal, innocent victim' who is not responsible in any way for the violence done towards her (Chesney-Lind, 2017) and the 'dangerous, deviant other' as a 'perpetrator', suggesting violence is done by *"a few deviant, sick men rather than as a socio-cultural problem that pervades society"* (Mowat et al., 2016, p.26).

Recognising the persistent need of the *thoughts that think thoughts* in the literature to separate and individualise the crises of 'mental health' and 'domestic violence', I recognise the situated character of these *knowledges that know knowledges.* From my location in the psychology discipline in Aotearoa, attending to the social determinants of health, the colonial imposition of a patriarchal social structure and the precarious conditions of everyday lives means recognising that psy-discourse claims to 'normalcy' are culturally specific and situated in Eurocentric knowledge systems that privilege a bounded and personally responsible individual (Braidotti, 2019a; Coombes et al., 2016; Haraway, 2016; Robertson & Masters-Awatere, 2007; Parmar et al., 2020; Webb, 2018). These situated psy-discourse claims to 'normalcy' pertain to **both** constructions of 'mental health' (ab)normalcy **and** gender norms, for as Elizabeth Tolmie (2018, p.56) asks: *"if abusive behaviour exploits existing gender norms, where does 'normal' end and 'abuse' begin?"* Her question for me encourages a consideration of how (culturally specific) psychological knowledge production and practice is implicated in the policing and reproduction of gender norms through processes of normalisation, recognising a collusion with the knotted relationships between colonisation and patriarchy.

Attention to psy-expertise's collusions with the knots of colonisation and patriarchy contributes to becoming response-able within a psychology discipline that is afforded powers of discursive representation regarding claims to normalcy. In this becoming, I take up an invitation offered by Member of Parliament and co-leader of Te Pāti Māori, Debbie Ngarewa-Packer (2021) to becoming tangata Tiriti. Tangata tiriti is a location in a relationship between people who are indigenous to Aotearoa New Zealand (tangata whenua) and those who are welcomed to the land and hosted by tangata whenua (tangata Tiriti). In this relationship tangata Tiriti actively respect and orientate their becoming around Te Tiriti o Waitangi, a document signed by some indigenous chiefs and British colonial settlers in Aotearoa in 1840. Learning from Debbie, I understand that Te Tiriti was signed by tangata whenua in the spirit of forming lifelong relationships between settler and indigenous peoples; it was a treaty for *British colonial settlers* in Aotearoa because they did not fall under British law, and a treaty to protect tangata whenua social structures and systems of lore. However, Te Tiriti has not been honoured or respected by settlers or their descendants in Aotearoa, and instead British colonial systems and patriarchal social structures were/are imposed, meaning tangata whenua have been/are subject to multiple forms of colonial violence (for at least the last 160 years). As a descendant of settlers who voyaged to Aotearoa by virtue of Te Tiriti, and as someone who knows no other 'home' but the land of Aotearoa, I embody response-abilities for colonial violences done to tangata whenua and have committed to projects of decolonisation. Debbie's offering of Tangata Tiriti helps me locate myself in these response-abilities, suggesting that as I acknowledge and understand (as ongoing processes through relationships) the harms of colonial violences and use these understandings to increase my response-abilities, I stand alongside tangata whenua, privileging and honouring Te Tiriti o Waitangi as a reason I am welcomed and hosted here in Aotearoa.

Taking up the invitation to becoming tangata Tiriti means listening and responding to the ways in which British colonisation of Aotearoa from the 1800s onwards has privileged non-indigenous (and specifically European) ways of knowing, seeing and understanding, attempting to delegitimate and suppress indigenous systems of expertise (Mikaere, 2011; Smith, 2012). Coombes et al. (2016) locates psychology as a discipline here in Aotearoa within *"the historical context of imperialism and the ongoing practices of colonisation"* (p.438), while

Webb's (2018) action shows how the practices of colonisation and psychology converge through psy-theories of criminality and risk assessment tools that privilege Eurocentric individual norms. Through the negation of the systemic and structural conditions that underpin 'risky' behaviour, tangata whenua are positioned as a particular type of *"'cultural' risk subject"* (p. 17) to be managed. Within mental health responses, Arrigo (2013) critiques the neoliberal focus on individual risk management as a *"totalising madness"*[7] (p. 674) that recognises difference (from culturally specific sameness) as only deviant, deficit, criminal or pathological. A recognition of difference as 'risk' reinforces processes that (re)produce *either* a conforming *or* a deviant citizen that form a Society-of-Captives where everybody is implicated in captivity – not only through punitive justice system responses but also through limitations on possibilities of *"doing humanness differently"* (p. 673).

By recognising the knotted social relationships of colonisation, patriarchy, imperialism and neoliberalism that underpin the dominant *thoughts that think thoughts* and *knowledges that know knowledges* about 'domestic violence' and 'mental health' crises, the perspectival and hence limited character of the expertise can be acknowledged and psychology's relationship to the *totalising madness* is more adequately understood (an experience of joy). With a focus on individual difference through 'risk', psy-expertise becomes preoccupied with a figuration that emerges at the meeting of the two crises of 'mental health' **and** 'domestic violence', and it is this figuration that contributes to a dis-abling of response-abilities in system responses.

The figure of 'a risk to be managed'…

Through the individualising and separation of the two crises in psy-expertise that has gained powers of discursive representation, intervention at the individual level becomes legitimated if, as I experienced on my day with April, experts can decide *which* crisis is occurring (*either/or*). As the two crises are teased out of the social fabric of everyday lives, a figuration is constructed with them; the figure of *'a risk to be managed'*. Figurations are important for a cartographer, as they *"are localised, situated, perspectival and hence immanent to specific conditions: they function as material and semiotic signposts for specific geo-political and historical*

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[7] As we move, *"totalising madness"* becomes a word gift from Arrigo

locations" (Braidotti, 2019a, p. 136). Figurations help us follow the flows of social power relations and knowledge claims to adequately understand the complexity of power as repressive (potestas) but also power as affirmative and transformative (potentia) (Braidotti, 2019a). The figure I sketch of *'a risk to be managed'* is not static, fixed or bounded, but is in process and always moving to seek connections to become otherwise (Braidotti, 2010).

April's partner as 'a risk to be managed'

In the *either/or* scenario on my day with April (*either* a mental health crisis *or* a domestic violence crisis), the decision rested with psy-experts on the mental health crisis team. As there was a concern of suicide for April's partner, the crisis team had been called to assess him under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to determine if he should be subjected to compulsory treatment. Under the Act, assessing clinicians known as Duly Authorised Officers (DAOs) determine whether a person is experiencing:

> *mental disorder, in relation to any person, [which] means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –*
>
> *a) poses a serious danger to the health or safety of that person or of others; or*
>
> *b) seriously diminishes the capacity of that person to take care of himself or herself*
>
> Mental Health (Compulsory Assessment and Treatment) Act 1992, section 2

In this context 'mental disorder' is a legal term, not a medical one, though the use of designated health professionals and their expertise when deciding whether one is 'mentally disordered' conflates the knowledge territories of law, psychology and medicine. The conflation of knowledge territories in the Act binds assessments of *'serious danger'* to abnormality, (re)producing the causal assumption that it is an individual's deviance from normality that produces the 'risk' of *'serious danger';* a reinforcement of the *totalising madness*. The reproduction of the assumption of individual difference as risk legitimates detainment and compulsory treatment of the individual (April's partner) once assessed as 'mentally disordered'.

I remember April and her concern with her partner's mental *distress* and plan to take his life, and how she had searched for *"help"* and *"support"*. I reflect on how the clinicians assessing her partner were instead bound to assess for *disorder* and risk of *danger*, and to provide *treatment*. Large and Nielsson (2011) raise statistical, ethical and empirical concerns about the use of risk assessment in mental health services, drawing attention to the significantly high number of false positives, the base rate problem (i.e. that rare events are practically impossible to predict), the disputed link between mental disorder and danger or risk, and the need to acknowledge *"the severe limitation in our [mental health professionals] ability to predict future harmful events"* (p.417). Additionally, Szmukler and Rose (2013) raise concerns that a preoccupation with risk moves a clinician away from being able to respond with therapeutic interventions and towards focusing on regulation and control, damaging the relationship and potential trust with the person being assessed. Notably, the discussion document out for public consultation regarding repealing and replacing the Mental Health (Compulsory Assessment and Treatment) Act 1992 recognises how the current legislation may be emphasising a risk-averse culture in mental health services, citing the voices of lived experience from *He Ara Oranga* as evidence (Ministry of Health, 2021a).

Despite the Mental Health (Compulsory Assessment and Treatment) Act 1992 legitimating clinicians to *"consult the family or whānau[8] of the proposed patient"* when conducting an assessment, the crisis team did not speak to April that day. Perhaps if they had seen the bruises April wore, or heard her concerns regarding her partner's mental distress, they would have made a different assessment than they did in determining her partner did not meet the criteria for mental disorder (posing a serious danger to himself or others due to an 'abnormal state of mind'), but April was grateful for the decision they had made. She did not want her partner subjected to compulsory assessment and treatment, she had wanted *"help"* and *"support"*. April

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[8] The 'or' between the terms 'family' **and** 'whānau' in the Act troubles me, as Naomi Simmonds (2011) teaches me *"the meaning of whānau…is not simply meant to denote the nuclear family - mother, father and children. Whānau is much more"* (p.6), including extended family, and broader kinship connections through social units (hapū and iwi) and spiritual worlds. I have also learnt from Virginia Tamanui (2012) that understandings of 'whānau' are multiple, fluid and have been textured through responses to the imposition of colonial and patriarchal social structures. To open spaces to recognise tangata whenua social structures and systems of lore (that have been in place prior to British settler arrival) requires not an 'or', but an 'and'….and, and, and….

told me she had previously watched her partner go through the processes of being sectioned and detained under the mental health legislation and was concerned it had added to her partner's experiences of trauma. Patterson et al. (2018) amplified the voices of service users who have been through the compulsory assessment and treatment process in Aotearoa who echoed similar concerns and experiences as April (for her partner) did; stories of experiencing stigma, coercion, seclusion and restraint while within services. Wanting to avoid detention and compulsory treatment was why April had called the *mental health crisis team* that day, she had told me, rather than the police. It was her hope that *"help"* and *"support"* could be provided to her partner by the psy-experts without escalating to a level of compulsion and coercion. However, as her concerns had increased and the crisis team was unavailable, April had rung the police who had (eventually) brought her partner to the station under the mental health legislation, activating the assessment process by the mental health crisis team.

Police are often located as first responders for mental health crises, reflected in New Zealand Police data which demonstrates officers respond to more than 100 mental health call-outs across a 24 hour period (NZ Police, 2019), and have experienced a sustained increase in calls for service for mental health events across the last five years (NZ Police, 2021). Police officers accept their role here but often struggle to fulfil it. Just how their 'role' is enacted in the context of relatively recent de-institutionalisation of mental health care, increasing unsustainable demand for mental health services and the increasing precarious conditions of everyday lives is open to complex social expectations. While they are formally expected to keep the peace and protect people from harm in their communities, they are often expected to take on the role of 'front line mental health workers' which they are not adequately trained for (McLean & Marshall, 2010). There are several reports across the literature of feelings of powerlessness and resignation by police officers as they are frequently placed in situations where they feel they are the only people available to help individuals experiencing mental health crises, but they do not feel adequately trained or resourced to respond (Gur, 2010; Holman et al., 2018; Marakowitz & Watson, 2015; Marsden et al., 2020; McLean & Marshall, 2010; Ogloff et al., 2020).

It is understandable why the police officers chose to temporarily detain April's partner under mental health legislation; from their vantage point they had heard April's concerns about her partner planning to take his life (posing a serious

danger to himself) and they had their own concerns about patterns of harm enacted towards April by her partner (posing a serious danger to April). They also knew April's partner had a mental illness diagnosis and may have been informed by the dominant knowledge claims that link such diagnoses to domestic violence perpetration. For example, Shorey et al. (2012) demonstrate positive correlations between a number of mental illness diagnoses and intimate partner violence (IPV) perpetration, noting that *"as the frequency of mental health problems increased, the frequency of IPV perpetration also increased"* (p. 746). Similarly, a longitudinal study by Yu et al. (2019) demonstrated men with schizophrenia-spectrum disorders, bipolar, depression, anxiety, substance use disorders, personality disorders and attention deficit hyperactivity disorder (ADHD) were more likely to perpetrate IPV against women when compared to the general population. Connections here are made between treating mental disorders and reducing IPV perpetration that continue a (hyperintesive) focus on an individual; for example, Yu et al. (2019) suggest treating mental disorders with particularly high correlates to IPV perpetration could *"potentially reduce the risk in these groups"* (p. 13) and Spencer et al. (2019) explain *"neglecting to address the mental health concerns of IPV perpetrators is a missed opportunity to decrease potential recidivism of IPV perpetration and save lives"* (p. 7). Men recognised as 'perpetrators' have suggested an unmet need for mental health care contributed to their behaviour (Lipsky et al., 2011, Roguski & Gregory, 2014) and domestic violence practitioners have reproduced this focus on an individual's need by referring men onto mental health services as a way to treat the originating 'causes' of their behaviour (Short et al., 2019).

Additionally, through a continued focus on discrete acts of violence and categories of 'mental illness', prevalence literature estimates the rates of violence toward family members by patients with severe mental illness are high; for example, Kageyama et al. (2015) found 27.2% family members had been a target of this violence over the past year and 60.9% over a lifetime, while Vaddadi et al. (2002) demonstrated at least 40% of family carers of patients registered with a community mental health service had experienced some form of violence (from their loved one) within the last year. Solomon et al. (2005) suggest a conservative estimate of the rates of violence towards family members by a relative with a psychiatric disorder would sit between 10-40% since diagnosis. The linear connections between 'mental illness' and 'domestic violence perpetration' continue to produce a preoccupation

with an individual *'risk to be managed'* – reproducing the legitimacy of the police's authority to 'keep the peace' by attending to individual deviancy or dangerousness (Arrigo, 2013) rather than acknowledging the social power relationships that form the key social determinants of health.

From the police's perspective and their (understandable) focus on the risk April's partner may pose (to April or to himself), two variations of the figure of 'a risk to be managed' were possible. *Either* April's partner could be experiencing a mental health crisis and at 'risk' to himself, *or* he could be experiencing a mental health crisis and at 'risk' to April. However, despite both April and the police emphasising concerns regarding April's partner's mental distress, the crisis team suggested the problem instead lay in his relationship with April, thus dis-abling the mental health team's response-abilities. Both April's vantage point *and* the police's vantage points were eclipsed by the clinical knowledge of the psy-experts (the same *knowledges that know knowledges* of the psy-experts that dominate the clinical and academic literature). Holman and colleagues (2018) tell similar stories of police experiences with mental health legislation here in Aotearoa where almost half of those persons brought in by police under mental health legislation were released following assessment with no further supports. While April's partner may not have met the threshold for compulsory assessment and treatment, both April and police had raised concerns about his mental wellbeing. In the absence of a legitimated 'mental disorder', the experience of his mental distress (and how that had impacted April, her response-ability and her safety) was missed and no immediate response from the psy-experts could be provided. Instead, April's partner was drawn into the figuration of *'a risk to be managed'* through a discourse of criminality. Despite April's constant repeated calls for *"help"* and *"psychological support",* she remained unheard.

Perhaps the mental health crisis team *had* seen the bruises and blood on April, or *had* deduced that she was a 'victim' of domestic violence, and did not want to be complicit in her partner using the label/category of mental health dis-ability to refrain from accepting response-ability for enacting violence. This would be a reasonable concern, as Buchbinder (2018) explains men use the linguistic techniques available to construct how they perceive their reality of the violence, and Hydén (2013) demonstrates that men may use language given to them by medical expertise to adopt a subject position that neutralises their response-ability for violence. Coates

and Wade (2004) analysed sexual assault trial judgements and found that judges tended to use discursive devices related to psychological knowledge that mitigated the offenders' responsibility for violence by portraying the offenders as 'out of control'. When psychopathology could be assigned to an offender by expert psy-testimony, response-ability was reduced (or even removed) due to the offender's mental disorder. In some cases, the offender was *"effectively transformed into a victim"* of his disorder and the violence was concealed (p. 511). These discursive representations proliferate through the Society-of-Captives, reproduced through storied explanations in academic, media, clinical and social communities, legitimating techniques and technologies that manage a risky figure (Arrigo, 2013).

Similarly, differently, the discourse of criminality and its language of 'perpetrators', 'victims' and discrete *acts* of violence rests upon the same Eurocentric knowledge claims that inform considerations of (ab)normalcy pertaining to mental disorder and risk, as offending is understood as a product of *"negative emotions and antisocial thoughts"* (Webb, 2018, p.11) – an individual abnormality. Through the *totalising madness* an emphasis is placed on the individual response-ability of the 'perpetrator' to submit to the technologies of the psy-disciplines for the restoration of normalcy to avoid further criminal behaviour. Indeed, 91% of the prison population of Aotearoa has a mental health diagnosis (Te Uepū Hāpai i te Ora - Safe and Effective Justice Advisory Group, 2019), and there is a reported unmet mental health care need from 'perpetrators' of domestic (or family) violence (e.g. Lipsky et al., 2011; Roguski & Gregory, 2014; Short et al., 2019). However, work with mental health practitioners demonstrates there is a reluctance amongst them to address perpetration (and victimisation) of domestic violence when working with clients, as the practitioners suggest attending to 'domestic violence' is not within their boundary of expertise. Instead, clinicians suggest their focus should be only on 'mental health', fragmenting people's lives and experiences (Nyame et al., 2013; Rose et al., 2011; Trevillion et al., 2012). If practitioners do attend to the violence, they report not knowing how to or feeling unable to provide safety responses for those they are working with, which practitioners suggest may deter them from attending to the violence again in the future (Howard et al., 2010).

A dis-ability of clinicians to respond is unsurprising when the (hyperintensive) focus remains on individuals rather than attending to the precarious conditions of everyday lives and the patriarchal social power relations underpinning

manifestations of (gendered) violence and crime. The gender-neutral terms 'victim' and 'perpetrator' continue to individualise response-ability for complex social problems (NZFVDRC, 2020) and a focus on individual (ab)normalcy explains 'domestic violence' through personal deviance, deficit or pathology (difference as risk). Hence, it is suggested the criminal justice system is not designed to respond to domestic violence and may continue to reproduce patterns of harm when referring people onto other agencies, and by negating the structural and systemic conditions that enable discrete *acts* of violence (Tolmie, 2018).

It was asking a lot of April then, for her to recognise her partner as *'a risk to be managed'* through the language of 'perpetrator' and 'victim' when doing so may have prevented her partner from getting the *"help"* and *"psychological support"* she thought he desperately needed at a moment of crisis. While he may not have met the legal threshold for 'mental disorder', both April and the police officers thought he required some sort of psy-expertise in response to his mental distress. However, the system response could only see one figure to grant an immediate crisis response to from psy-expertise: the figure of a 'mentally disordered' man who is *'a risk to be managed'*. With the clinicians deciding April's partner did not fit this description, the figure connected with the criminal justice discourse where it was reproduced as the figuration of a 'violent perpetrator' who is also *'a risk to be managed'*. The fragmentation of different individual 'risks' sets up different (fragmented) system responses; *"compulsory assessment"* and *"treatment"* for the former figure, criminalisation and punishment for the latter. Where in the system could the figure move from its risk framing and connect to be seen as one who needed *"help"* and *"psychological support"*, not management or risk assessment? Concerningly, once the experience had been recognised through criminal justice discourse as a 'domestic violence crisis' rather than a 'mental health crisis', the figure also engulfs April.

April as 'a risk to be managed'

Dominant psy-knowledge production makes a convincing case for the impact of experiences of domestic violence on mental health symptomatology such as depression, post-traumatic stress disorder (PTSD), borderline personality disorder (BPD) and self-harm (Ellsberg et al., 2008; Howard et al., 2015; Humphreys & Thiara, 2003; Roberts et al., 1998; Sediri et al., 2020; Shaw & Proctor, 2007). It has been suggested that psy-diagnostic manuals, including the *Diagnostic and Statistical*

Manual of Mental Disorders-V (DSM-V) and the *International Classification of Diseases-10 (ICD-10)* should work to incorporate domestic violence as a risk factor in conditions where a significant link has been demonstrated (domestic violence's impact *on* mental health) in research. The suggestion is that in doing so, psy-practitioners would be able to recognise when someone sitting in front of them is experiencing *mental distress* in relation to their everyday living conditions (i.e., because they are living in the storm of violence) rather than continuing to reproduce diagnosis of individual pathology and disorder (Bunston et al., 2017). Though it is useful to consider an individual in context, practitioners should remain wary of reproducing the figure of *'a risk to be managed'* by moving the risk from an individual's 'mental health' to an(other) individual's 'violence'. It is instead important to recognise the precarious conditions of everyday lives as manifestations of the knotted relationships of colonisation, patriarchy, imperialism and neoliberalism that are signposted by the figuration; in this vein Short et al. (2019) suggests a move away from individualised framings that dis-able system responses and towards recognising family violence as a form of social entrapment within a context of colonisation here in Aotearoa. Once both 'family violence' and 'mental illness' are recognised as problems of social power relationships, preoccupation with an individual as the only site of response can be released (an increase in understanding experienced as joy).

Recognising the ways in which 'family violence' and 'mental illness' converge as issues of social power relationships could increase the response-ability of clinicians in a disruption to boundaries of expertise; currently even when clinicians are aware of a woman's (historical or current) experiences of violence, it is not often seen to be relevant to her mental health symptomatology or as an area of response for mental health professionals, and so the preoccupation with an individual and the fragmentation of their lives continues (Humphreys & Thiara, 2003; Short et al., 2019). The NZFVDRC (2020) listens to and amplifies people's stories of the harm of possible misdiagnosis, inappropriate treatment and stigmatisation when abuse-related trauma remains unacknowledged in the lives of people constructed as 'mentally unwell', and April shared similar stories with me on the day I am remembering. As April and I talked in the foyer of the police station, she told me that she had been brought into the mental health system since the conception of her relationship as she struggled with feelings such as sadness, anxiety, worthlessness,

anger and suicidal ideation and planning. While her experience of violence had been acknowledged by clinicians in passing, she told me she had still received various diagnoses including BPD and PTSD, had been prescribed psychiatric pharmaceuticals and was on the waitlist for talk therapy. April explained to me how these diagnoses and the 'treatment' they legitimated revolved around attending to her pathology as an individual (*"the ways in which I am broken"*), with clinicians at times suggesting she was partly responsible for the violence she was experiencing *because* of her pathology. She told me she did not trust the clinicians who were bound to assess her yet could not adequately understand her experiences, but she (like her partner) needed *"help"* and *"support"*.

As I listened to April explain her interactions with mental health clinicians to me, I connected to Michelle Brown's (2013) response to the *totalising madness* of Arrigo's (2013) Society-of-Captives. Brown (2013) suggests *"the first step in overturning the "society-of-captives"…is simply allowing a statement to begin here in the realm of structural violence without the inevitable follow-up therapeutic, correctional response of responsibilizing the individual"* (p. 697). To move away from responsibilising the individual means to *listen to pain for real*[9] as an ethical response-ability to the other where possibilities materialise. Listening to pain for real moves away from the assumptions of *"neurobiologically deficient subjects"* (Walker et al., 2015, p. 504) and the *"god trick"* (Haraway, 1988, p.581) of a situated, partial, limited knowledge system; it moves the figure of *'a risk to be managed'* that engulfs both April and her partner to open spaces for other-wise understandings of their experiences. Without this movement, April continues to be seen only as a 'victim' at *risk* of a 'mental illness' and at *risk* of suicide; an individual '*risk to be managed'* through medicine and therapy. Here, even if domestic violence is acknowledged through a DSM-5 or ICD-10 diagnosis as has been suggested (e.g., Bunston et al., 2017), the level of intervention remains at the individual. The response-abilities (for safety and for mental health 'improvement') remain with the 'victim' of violence, with April. Instead, listening to pain for real offers a pathway to recognising the experiences of social entrapment within a patriarchal structure (Mikaere, 1999; Short et al., 2019; Tolmie, 2018) and the precarious conditions of everyday lives (Hodgetts & Stolte, 2017; Patterson et al., 2018; Rose, 2019), contributing to an increase in the

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[9] A word gift I accept from Brown's (2013) work with Amy Johnson

adequacy of understanding (an experience of joy) and an increase in response-ability of mental health professionals to provide safety-focused responses.

Without listening to pain for real, women experiencing violence are placed in challenging situations through their interactions with mental health services. In research by Laing et al. (2010) women recalled how their partner would accompany them to clinical appointments and often clinicians would believe their partners' stories regarding the women's symptomatology rather than what the women said themselves. Some also recall being told by clinicians that they would be denied further service provision if they did not 'comply' with prescribed psychiatric medication requirements. In these situations, the women felt the clinicians were enabling their partners to extend patterns of abuse and entrapment by providing evidence of mental health dis-ability to confirm partners' claims that the woman is 'crazy'. Humphreys and Thiara (2003) listened to similar stories from women experiencing violence and were told of victim blaming, minimisation and/or total ignorance of the violence by clinicians in relation to the mental health concerns of women categorised as 'victims'.

Research has also documented how labels and categories of mental illness follow women like April and can contine patterns of harm and entrapment through multiple axes of system responses – the persistence of the figure of *'a risk to be managed'*. Psy-expertise is used in the Family Court to frame women as 'alienating mothers' or 'mentally unwell', and may result in the removal of their children and/or the denial of the abuse perpetrated against the women and their children (Backbone Collective, 2020; Elizabeth, Gavey & Tolmie, 2010; Mackenzie, Herbert & Roberston, 2020). Hager's (2007; 2011) work speaking with responders in women's refuges also connects here, as she demonstrates how the suggestion that a woman has a mental health or drug and alcohol problem(s) can exclude her from entering or remaining in a refuge to escape domestic violence.

As system-responses continue to recognise those like April and her partner through the figure of *'a risk to be managed'*, the experiences of a 'mental health crisis' and a 'domestic violence crisis' remain separated and fragmented, yet attached and connected. By isolating the experiences into categories resulting in a suggested requirement for inter-agency working with firm boundaries of expertise (e.g. Polaschek, 2016; Short et al., 2019), mental health practitioners, police and domestic

violence professionals remain dis-abled in their response-abilities and people like April and her partner are missed in an *either/or* response. Certainly April and her partner fell into a crevice as the system response understood their experience as individual crises on the day I am remembering, and they walked out of the police station having denied any 'support' we (as a system) could offer, back into the conditions of their everyday lives; a space Rose (2019) suggests many have termed 'the community'.

Management of the figure in 'the community'

The term 'the community' is often used to acknowledge the movement of mental health care during the latter part of the twentieth century out of institutions to try and situate responses within the context of everyday lives. However, in the face of an ill-prepapred community care system and a socially inequitable society (i.e., without attending to the patriarchal social structure and the social determinants of health), it is suggested this movement has contributed to the increased focus on managing 'risk' rather than providing therapeutic care (Rose, 2019) – the persistance of the figure who is *'a risk to be managed'.* Through a focus on risk, the location of front-line police officers as first responders to 'mental health crises' remains legitimated, as do their feelings of frustration and powerlessness as they do not feel adequately trained or resourced in their response-abilities (Gur, 2010; Holman et al., 2018; Marakowitz & Watson, 2015; Marsden et al., 2020; McLean & Marshall, 2010; Ogloff et al., 2020). What would happen the next time April's partner needed help that was beyond her supportive capacity, and the crisis team were unavailable immediately as they had been on the day I am remembering?

Police response-abilities

Though police officers accept their response-abilities in responding to 'mental health crises', their feelings of frustration and powerlessness are not without consequence for those they are responding to. For example, Jones and Thomas (2019) demonstrated that two thirds of mental health service users rated their last police encounter negatively, and O'Brien and colleagues (2020) demonstrated that people experiencing mental health distress who come into contact with police are more likely to face an armed police response, and for that response to prove fatal, than those who do not present with mental health crises. Evidence also suggests

police are twice as likely to discharge their tasers at mental health events rather than at criminal arrests (O'Brien et al., 2010) and that police are more likely to use force when mental health services were less available to officers (Holman et al., 2018). Police response to 'mental health crises' can also be the site of compounding oppressions; for example in Aotearoa, tangata whenua are more likely to be categorised with a mental illness (Ministry of Health, 2021a) and are significantly disproportionately overpoliced in community settings (e.g., Holman et al., 2018).

Thinking with April, there is also a concern that had she felt that her partner needed support that was beyond her individual capacity and the crisis team remained immediately unavailable, she would not call the police again; women who experience domestic violence suggested that following a negative encounter with police they were unlikely to call them again in a crisis (Douglas, 2019). Given research demonstrating officers feel like responding to domestic violence detracts from their ability to do 'real' police work (Grant & Rowe, 2011; Maple & Kebbell, 2020; Segrave et al., 2018), and some endorse myth-based beliefs about the violence, such as women and men are equally violent and staying is more dangerous than leaving (Ward-Lasher et al., 2017), the potential reluctance of women to call for help is understandable. However, as I saw with April on my day with her, even if faced with a skillfull, careful and compassionate police officer, being practically able to offer only a criminal response to someone asking for *"help"* and *"support"* can dis-able officers' response-abilities and best intentions. It is notable here that across homicide or family death review committees it is often recognised that the homicide 'perpetrators' and 'victims' both had contact with multiple services (e.g., mental health, addiction services, police, domestic violence agencies) prior to the death event (e.g., Murphy et al., 2016; Robinson et al., 2019; Short et al., 2019). These contact points are often noted as forms of missed opportunities, yet it is worth asking what 'opportunities' would have been enabled given the conditions of everyday lives continue to be understood as separate and fragmented yet attached and connected crises; individualising crises and individualising response-abilities.

Domestic violence practitioner response-abiliites

From my location as a 'victim' service provider, I had a response-ability to follow up with April in 'the community' after her visit to the police station that day. It was a difficult phone call to make, given I was dis-abled within a system response

and was un-able to provide the *"help"* and *"support"* April was searching for. I was dis-abled further as the number she had given me was disconnected and I was never able to make contact with April again. In the literature I searched for the voices of family violence practitioners to try and learn how they had navigated the entanglement of two crises (mental health **and** domestic violence) with those they worked with and for, to see whether they had found other ways to become response-able. However, research privileging family violence practitioners' voices and experiences regarding the entanglement is very limited, and what is there is translated through the system responses in much the same way April's experience was: the fragmentation of a crisis into the discrete categories of *either* 'mental health' *or* 'domestic violence'. Mengo et al. (2020) spoke to domestic violence service providers who work with 'surviviors' of violence who are (also) categorised with a 'mental health disability', and service providers spoke of many challenges in their work at the intersection of 'mental health' **and** 'domestic violence' crises. Challenges included limited access to mental health clinicians and programmes, as well as long waiting lists for mental health support for their clients. But often more pressing was *"the overwhelming, often fundamental, unmet needs (e.g. lack of food, housing, and transportation) of survivors that take priority and may overshadow directly addressing mental health struggles"* (pp.187-188). These unmet needs are fragmented into further pockets of system responses and multiple agencies, and clients had to attend multiple appointments to receive support, often having to prioritise some appointments (and therefore needs) over others. To attend these multiple appointments, clients required additional resources such as reliable transport and childcare assistance.

As I read the stories in Mengo et al. (2020) about service providers trying to assist their clients traversing a fragmented and demanding system, I remembered Hodgetts et al.'s (2013) work with families in need and the recognition that *"this cluster of services does not consitute a coherent welfare system; rather, it is the clients who create a 'functional' system through their efforts"* (p.43). The situatedness of the knowledge informing system responses here is necessary as the hyperintensive focus on the (personally responsible) individual negates focus on social determinants of health and social entrapment, and enables fragmentation and incoherence. From here, the *'emotional barriers'* reported by domestic service providers when working with those experiencing 'mental health' crises are

understandable, such as being afraid to discuss mental health issues or not knowing how to respond (Mengo et al., 2020), as only fragmented individual level responses are legitimated for service providers through a system response for what are social and structural issues.

There are crevices and shadows in the fragmented and incoherent system responses, and Heward-Belle et al.'s (2019) research with domestic violence service providers working with men who have been labelled 'perpetrator' offers an insight to one such shadow. Work with these men is often *invisible* at policy and funding levels, with a focus instead on safety responses for women and children (the fragmentation). However, service providers recognise that working with men is a necessary part of enabling safety for women and children, and may do so anyway in the absence of overarching institutional support. Heward-Belle et al. suggest doing complex work with these men *"within the shadows"* can constitute *"dangerous practices"* (p.378) for the service providers as they are without sufficient safety procedures, funding arrangements, governance structures and supervision.

The dearth of research privileging family violence practitioners' voices is troubling, as those voices who are documented in the literature suggest that they respond to people experiencing an entanglement of (at least) the two crises (mental health and domestic violence) on *almost a daily basis* (Mengo et al., 2020) and that important aspects of their work are often *invisible* at policy and funding levels (Heward-Belle et al., 2019). Additionally, family violence practitioners are located to respond in 'the community' and often work with people in the context of their everyday lives, rather than through an institutionalised response. As I have situated and recognised the perspectival character of the dominant knowledge claims pertaining to the (apparently separate) two crises of 'mental health' **and** 'domestic violence' (culturally specific, individualised and legitimated through the discourses of *either* psy-expertise *or* criminal justice), it becomes possible to recognise the need to open and connect these knowledge claims with forms of expertise situated elsewhere that are other-wise. *"It matters what thoughts think thoughts, it matters what knowledges know knowledges"* (Haraway, 2016, p.35). The dominant knowledge claims pertaining to the two crises dis-able system responses towards people like April and her partner, and lead to feelings of frustration and powerlessness by those in service provider positions. The dominant understandings of the experiences of the two crises remain *inadequate* and in moving to increase the

adequacy of our knowledge claims (Braidotti, 2019a) and therefore enhance our response-abiliites (Haraway, 2016), it matters to ask who 'we' might be (Braidotti, 2019a). Along with April, the domestic violence practitioners working in 'the community' are also *"missing peoples"* in our fields of discursive representation on these matters (Braidotti, 2010, p.414). A thickening of their voices and expertise within the literature is warranted, and not only to increase adequacy of understandings; it has also been requested in and through voices like April's and her partner's.

Service user voices

Unsurprisingly given the dominant knowledge claims explored above, the experiences of 'service users' at the intersection of the two crises are also fragmented and separated in the literature. However, at both the sites of 'mental health' **and** 'domestic violence', service users state they would prefer community-based care solutions over formal institutionalised responses (e.g., Boscarato et al., 2014; Patterson et al., 2018; Roguski & Gregory, 2014; Short et al., 2019). For example, Roguski and Gregory (2014) spoke to former domestic violence perpetrators who had since ceased their use of violence (25 men and one woman) and all participants bar one rejected formal mental health services as a possible avenue of support. The rejection was not a denial of a need for mental health support – many participants were desperate for such support, but suggested the individualised focus of the psy-discourses and the knowledge production which rested on clinical knowledge claims pondering individual deficit or deviance was inappropriate for working through the participants' difficulties. The participants suggested this was because the clinical knowledge could not connect with the participants' experiences, and instead what was required was a community and peer response from people who the participants could relate to. Similarly, Boscarato and colleagues (2014) found that mental health service users prefer an informal or community response when they are in crisis, rather than a formal service response that would include police officers and mental health clinicians. A call for community wellbeing solutions was also apparent in *He Ara Oranga – The Governmental Inquiry into Mental Health and Addiction* (Paterson et al., 2018). Short et al. (2019) recognises the increasing harm formal service solutions may do towards indigenous peoples and other marginalised communities especially, as these knowledge claims that privilege individual deficit

or deviance rely on colonial discourses of medicine and pathology, rendering alternative ways of being human and doing humanness through the figuration of *'a risk to be managed'* (Coombes et al., 2016).

There is then a need to situate knowledge pertaining to the intersection of domestic violence and mental health crises within the community, given the expertise of those who respond, daily, at the intersection of recognisably complicated crises (Mengo et al. 2020). Having recognised the situated and perspectival character of the dominant *knowledges that know knowledges* in the academic literature, connections and openings become possible with other forms of expertise (Haraway, 1988). I have drawn the figure from these dominant knowledge claims of *'a risk to be managed'*, a figure that tenaciously persists from the vanatage point that is privileged in the literature and formal system responses. How does movement becomes possible for the figure, and how may response-abilities and adequacy of understandings increase if a different vantage point is recognised and legitimated too? Or in other words, what becomes possible if, having identified the dominant voice, we listen and learn to think with a *different* voice?

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CHAPTER THREE: *A* methodology...

"Our co-presence, that is to say the simultaneity of our being in the world together, sets the tune for the ethics of our interaction"

Braidotti (2006a, p. 408)

Having situated the knowledge claims from the academic and clinical literature that informed the response-abilities and dis-abilities of a system I was part of on my day with April, the situated, and hence partial and limited knowledges stretch and seek connections and openings with knowledges situated elsewhere that are other-wise. It is the partial perspective and *"the loving care people might take to learn how to see faithfully from another's point of view"* that increases the response-ability of knowledge claims and that "*promises objective vision*" (Haraway, 1988, p.583). Remembering cartographies are about questioning who 'we' might be through a *"theoretically based and politically informed reading of the present"* (Braidotti, 2010, pp.409-410), I stand at this point in my cartography already a 'we', with April and with the psychology assemblages from my student and teaching activities. Haraway (2016) has guided us with her focus on response-abilities and on how it matters *what thoughts think thoughts*. Through my situated telling of the literature, attending to the flows of social power relations and the knowledge claims of the dominant discourses pertaining to 'mental health' and 'domestic violence' crises, my figuration of *'a risk to be managed'* joins us too, as do the voices of domestic violence service providers and police officers. The figure of *'a risk to be managed'* moves for connections and openings to as it seeks to become understood otherwise; as a figuration that can connect with the *"help"* and *"support"* April had been searching for on the day I am remembering.

As *we* move towards connections, openings and otherwise understandings, Braidotti (2010) reminds me she's here as well, teaching me that for a cartographer *"the basic method is that of creative repetitions i.e. retelling, reconfiguring and revisiting the concept, phenomenon, event or location from different angles"* (p.412). On the day I am remembering with April, her partner was (re)configured as *'a risk to be managed'* that dis-abled the responses of the system I was part of and returned response-ability for safety, *"help"* and *"support"* to April. April also became

engulfed in the figuration. How might my story with April be *retold, reconfigured* and *revisited* through connection with an-other? *"It matters what stories tell stories"*, Haraway (2016, p.35) guides again. Given the need to hear the story differently, how do I (how do *we)* enable the conditions to hear the retelling and to *think with* an-other's viewpoint and expertise (their *knowledges that know knowledges* and *stories that tell stories*), rather than translating their vantage point back into a language that disrupts our response-abilities as a system, as we had on my day with April? In other words, how do we connect to the expertise of situated knowledges in a discipline built upon performing the *"god trick"* (Haraway, 1988, p.581)? Braidotti (2010) reminds me I will not find these conditions in *"the immediate context of the current state of the terrain"* (p.416). Instead:

> *they have to be generated affirmatively and creatively by efforts geared by creating possible futures, by mobilising resources and visions that have been left untapped and by actualising them in daily practices of interconnections with others* (Braidotti, 2010, p.416).

A thread from Community Psychology

Again, 'we' (me, April and her partner, the psychology assemblages, Haraway, Braidotti, domestic violence service providers, police, our figures of *'a risk to be managed'*) are not alone as we move for connection. Braidotti's (2010) call for interconnections with others, and the stretching and searching character of Haraway's (1988) situated knowledges share commonalities with the sub-discipline Community Psychology. Community Psychology has grown strong roots here in Aotearoa since the middle of the 20th century as a response to calls for bicultural psychological practice informed by the need to honour Te Tiriti o Waitangi; the subdiscipline in Aotearoa owes much to indigenous Māori scholars and scholarship (Roberston & Masters-Awatere, 2007). Noting that culturally specific (Eurocentric) psychological knowledge production and practice uses the powers of discursive representation afforded to processes of categorisation, measurement and normalisation to privilege sameness and to recognise different ways of being human as deviant, deficit or pathological (Arrigo, 2013; Mikaere, 2011; Smith, 2012; Sonn & Quayle, 2012), researchers sought to locate work within local community contexts and to recognise that *"there is more than one legitimate psychological approach to understanding the social world"* (Groot et al., 2012, p.5). Here in a small opening of

space, a focus on reciprocal relationships and experiential and collaborative knowledge is the heart work that moves the site of knowledge production and practices from the institution, situating it within 'the community' and constituting knowledge at the heart of the work that takes place in the context of everyday lives (Hodgetts et al., 2013; Robertson & Masters-Awatere, 2007; Sonn & Quayle, 2012). Importantly, this way of working recognises the institutional legal (Health Practitioners Competence Assurance Act, 2003) and ethical (Code of Ethics for Psychologists Working in Aotearoa/New Zealand, 2002) requirements for competence and accountability in psychological knowledge production and practice. Community Psychology principles take us beyond a simplistic ethical call to 'do no harm' and actively attend to the social power relationships psychologists are involved in and how the relationships implore us to recognise our response-abilities to social justice and society (Coombes et al., 2016).

We are in good company then and informed methodologically from over 40 years of research and practice as we move to listen to and learn to *think with* an-other.

Movement to connect with the Gandhi Nivas community

We begin, again, for a third time, with Gandhi Nivas.

My memory of my day with April came to the fore when I was introduced to Gandhi Nivas. Gandhi Nivas is a community-based response to family violence in collaboration with the New Zealand Police that began in Counties Manukau, Tāmaki Makaurau, Aotearoa New Zealand. The community collaboration attends to a 'need' that was recognised following the introduction of Police Safety Orders (PSOs) in the Domestic Violence Amendment Act 2009. PSOs were introduced as a way for police to provide immediate safety for those experiencing violence when responding to a family violence call out; the order served by an officer means the 'bound person' must leave and cannot return to their home for a number of days, as specified on the order (NZ Police, 2015). While PSOs aimed to enable immediate safety responses, in practice the Counties Manukau community felt this was not the case, as the PSO came with removal of men from their homes but no further support or safety provisions for them or their families. Through conversations between Counties Manukau Police and its South Asian Police Advisory Board after a relatively high

number of family violence deaths in the community, a decision was made to mobilise a community response that was the beginning of 'Gandhi Nivas' or 'house of peace' (Gandhi Nivas, 2021). Gandhi Nivas would provide a house where men could seek temporary accommodation after being served a PSO, as well as 24/7 support for the men *and* safety and social support for women and children.

Sahaayta Counselling Services, a community-based service already dedicated to culturally responsive domestic violence work with families in Counties Manukau, extended their response-abilities to the community and became the 24/7 service providers in the 'house of peace'. Sahaayta staff and volunteers knew the local community well, having established relationships through both their community practice and their entangled everyday lives as community members. With a strong commitment from local police and Sahaayta providing service through voluntary support, Gandhi Nivas opened the first house of peace in 2014 in Counties Manukau in the absence of any funding or resources from government; the community members were fuelled by their response-abilities to empower creative alternatives (Braidoitti, 2010). Attending to the needs of support from their community, Gandhi Nivas now has three houses of peace across Tāmaki Makaurau, extending the location of their response-abilities and authorising police to offer an alternative safety response to the men they serve PSOs to. The police's offer to the men is voluntary, yet it also enables an alternative safety response for the women and children – Gandhi Nivas can support the men in their moments of intensity in the temporary accommodation while also addressing the precarious conditions of everyday life and the patriarchal social entrapment experienced by families.

Gandhi Nivas has partnered with a research team at Massey University for the last six years to engage an evaluative programme of research for the creative alternative dedicated to safety provision. The research team's work has demonstrated that Gandhi Nivas' offer of temporary housing for the men bound by a PSO and unable to return to their home, as well as the 24/7 support for the family, is welcomed by Gandhi Nivas clients and community; nearly 60% of the men who come into the houses of peace as clients do not go on to reoffend. The process of engagement through offers of peace and support that build relationships enables men to return to Gandhi Nivas when they are struggling with their capacity to remain violence free, prior to police intervention (Morgan et al., 2020). Within the previous research, mental health incidents appear as frequently recorded codes in New

Zealand Police records of 'family harm episodes', and as I read through the research reports, I could not stop thinking about my day with April, the system's *either/or* fragmentation of her experience and my dis-ability as a service provider. I wondered what difference a house of peace made for people like April and her partner; how connections with Gandhi Nivas may *revisit, retell and reconfigure* April's story; how learning to *think with* Gandhi Nivas staff may increase and widen our adequacy of understandings and response-abilities towards people like April and her partner who are positioned within insitutionalised figures of *'risks to be managed'*.

"To see together without claiming to be another"[10]

Remembering that the partiality and limited character of situated knowledge is what enables response-able knowledge claims and the promise of objectivity (Haraway, 1988), the question becomes how to locate myself within the Gandhi Nivas community collaboration to hear and *think with* the vantage point of another. Remembering the inadequacy of the system translations I was part of on my day with April, here I search for connection and dialogue that increases the adequacy of our understandings as an ongoing process, not for fusion or synthesis which suggests some future completion point; multiplicity is embedded in a nomadic methodology that seeks to empower creative alternatives (Braidotti, 2010). While I began with an ethical commitment to becoming response-able to April and her story as well as the psy-assemblages I am immersed in, as I built relationships with the staff at Gandhi Nivas, my response-abilities were extended in creative ways, as were the adequacy of my understandings of responses that enable community safety.

I was welcomed to Gandhi Nivas as an extension of the relationships already built between the Massey research team and the community collaboration. At a meeting hosted by Sahaayta, I was introduced to the director and a house coordinator of Gandhi Nivas over cups of tea and samosas. In this meeting, the staff asked what *I* needed from *them* in terms of *my* research project, reproducing an institutional hierarchical relationship they were used to participating in where the researcher defines the primary needs of the study. In becoming response-able to Gandhi Nivas as a researcher, I took a breath and recognised the flows of social power relations in this interaction as I remembered the work of Linda Tuhiwai Smith who taught me

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[10] Haraway (1988, p.586)

that from her vantage point *"the term 'research' is inextricably linked to European imperialism and colonialism"* (2012, p.1). I (also) remembered the discipline I am located in has a history of over researching marginalised communities for the benefit of those in power, reproducing the power hierarchy that privileges the position of the researcher as the one who can know and the 'community' as the ones to be known *about* (Coombes et al., 2016; Roberston & Masters-Awatere, 2007). So as the breath flowed back out of my body, I answered the question with another: what I was here for was to learn to *think with them* about responding to the entwined crises of 'mental health' and 'domestic violence' – how could we work together to become more response-able?

My question and my attempt to reframe the social power relations in our interaction was met with the sharing of stories. The team members there that day started to share their experiences of responding to the *both/and* character of the two crises. The stories resonated with my readings of the literature – that domestic violence service providers were responding to these crises (*at the same time)* on almost a daily basis and this presented many challenges in their work. Having come from my location in the literature and my memories with April, and knowing that domestic violence service providers were on the margins of the powers of discursive representation, I realised one of my response-abilities focused on contributing to a thickening of their voices in the literature. We shared stories about our experiences (as responders and as researchers) of the entanglement of 'mental health' and 'domestic violence' crises. Though I did not speak April's story aloud that day, I realised the space we were opening was a space where April's voice might be able to be heard – not translated through 'victim', 'perpetrator' or 'mentally ill' - but heard for what she was trying to say: that she and her partner needed *"help"* and *"support"*. As I reflect on this conversation now and the space we were opening, I think with Braidotti again: *"critical theory is not about looking for easy reassurances but for evidence that others, here and now, are struggling with the same questions"* (2010, p.413).

Struggling with the same questions (regarding system responses to 'mental health' and 'domestic violence' crises) we were indeed, but here was a community of domestic violence professionals and police officers who had been working at the intersection of the two crises for over six years now; how did they respond? What creative alternatives did they empower? What did they need (and from who) to

increase their abilities to respond? These were the kinds of questions I would like to ask, I told the staff over samosas that day. *Could I come along to the houses and 'hang out'?*, we asked, at least an hour after it was initially asked of me what *I* needed from *them. Could I come and listen to more stories?* By the time we were saying our farewells that day we had made a collaborative commitment to how the research would proceed, recognising our intersecting needs as researchers and responders to the troubling convergence of the two crises of 'mental health' and 'domestic violence'. Through our conversations, the research goal became:

> **To listen to the stories of first responders to the entangled crises of 'mental health' and 'domestic violence' to hear how the crises are experienced by first responders and how the first responders can be further supported in their response-abilities.**

After meeting with the Gandhi Nivas staff that day, I realised I felt renewed in my ability to respond ethically – I had moved significantly from the day I felt disabled through system responses to April and her partner. Now I had connected with a group of people who recognised the difficulties of responding to the *both/and* character of 'mental health' and 'domestic violence' crises and were dedicated to addressing the difficulties as much as they were able to. But the stories of the Gandhi Nivas staff were not *the same* as my story with April and I needed to be careful not to listen to detect only the sounds I wanted to hear; instead, I needed to facilitate conditions for a hearing, a hearing on the terms of Gandhi Nivas. I understand the difference between *listening to detect sound* and *enabling a hearing* from Hine Waitere and Patricia Johnson's (2009) writing; they teach me that *"as we take up the invitation to speak, it does not guarantee a hearing"* and recognise their distinction between *listening* as detecting sound and *hearing* as actively participating in *"socially constructing relational meanings"* (p.14). A *hearing* would be important when it came to re-presenting the voices of Gandhi Nivas too, so they could be heard not through the frame of psy-expertise found in the literature, but as *a different voice* to enable dialogue (more on *a different voice* soon). How to hear the community then, to co-construct knowledge together, and to afford them the powers of discursive representation without imposing my own viewpoint as theirs? How to hear, think with and write with what I heard without becoming complicit with the advanced cognitive capitalism that *"profits from the scientific and economic understanding of all that lives"* (Braidotti, 2019b, p.41)? My answer, informed by

April, Braidotti, Haraway, the sub-discipline of community psychology, Waitere and Johnson, and the careful guidance by my supervisors, is by focusing on relational ethics.

Hanging out and hearing the stories that tell stories

After our collaborative discussions and decision-making regarding the research project with Gandhi Nivas, I proceeded to organise institutional ethics requirements. With my supervisors and in discussions with members of the HEARTH research cluster at Massey, we assessed the project as 'low risk' as I would be speaking to service providers about the experiences of their everyday working lives, at their workplaces, where I would be with the consent of their employer (see Appendix A for consent letter from Sahaayta). I would also be working in the context of research relationships already built between Gandhi Nivas and Massey University. I submitted a low-risk notification to the Massey Human Ethics Committee (see Appendix B) and drew together an information sheet (Appendix C), participant consent form (Appendix D) and a transcript release form (Appendix E). I arranged for a police-vetting check and filled out forms sent to me by Gandhi Nivas to fulfil their health, safety and confidentiality requirements. Additionally, given plans to speak to the police officers involved with Gandhi Nivas, we applied for and received ethics approval from the New Zealand Police Research Panel (see Appendix F for the approval).

The institutional ethical requirements were vital to my relationship with Gandhi Nivas as it was important that I kept their client information confidential as well as individual staff's stories; the entwining institutional and relational ethics facilitated the beginning of my 'hanging out' at the houses of peace. My understanding of 'hanging out' comes from Coombes et al. (2016); it is *"not only being with the people in our communities of interest but also…a strategy for reflecting on our own epistemological assumptions"* (p. 445). I connect this with Waitere and Johnson's (2009) emphasis on enabling conditions for a hearing. For Coombes and Te Hiwi (2007), *"hanging out involves sharing kai, waiting together in court, maintaining relationships with home, school and even in lockup"* (p.391). This critical ethnographic approach privileges relationships and understands thinking as a relational activity (Braidotti, 2019a) where meaning making is recognised as negotiated, co-constructed, *"locally relevant and sensitive to the social context"* of

everyday lives (Coombes et al., 2016, p.446). Here I reconnect to the (limited) domestic violence service provider voices in the literature, remembering their stories of navigating a fragmented and incoherent system with clients; a fragmented and incoherent system that persistently places response-ability on an individual to respond to the precarious conditions of daily lives (the social power relationships which form the key social determinants of health). To become response-able to Gandhi Nivas staff and to be able to *hear* the stories they could share with me to *think with* them (co-constructing relational meanings), I needed to move in and through their communities with them.

As I *moved* into the Gandhi Nivas communities, I brought my other locations with me – April and her partner came, as did the psy-assemblages, Braidotti, Haraway, the psy-expertise in the literature, the (other) voices of domestic service providers and police, and the figure of *'a risk to be managed'* too. These memories are important for my project of endurance, as I think with Braidotti again: *"Memories allow the subject to differ from oneself as much as possible while remaining faithful to oneself, or in other words: enduring"* (2010, p.416). To remain faithful to myself, to April and the other locations I brought with me, I engaged in a process of reflexive journaling throughout my ethnography, my 'hanging out' at the Gandhi Nivas houses. I also brought my memories to fortnightly supervision sessions where I would discuss (with my supervisors) the similarities and differences I was seeing and hearing at Gandhi Nivas and in my memories with April and the psy-expertise. These reflexive processes helped me continue to move to connect with the Gandhi Nivas staff and *think with* them when we were being in their community, together.

During the months of May to August 2021, I spent approximately 110 hours 'hanging out' with staff in the three Gandhi Nivas houses across Tāmaki Makaurau. I initially started going along with a member of Massey's research team who was already familiar with the houses of peace – he became a guide of sorts. The staff knew and trusted him as he had taken the time to build relationships and work with and for them, and they understood that I came from the same 'team' at Massey as he did. The staff were used to having 'researchers' and 'students' in the houses, they told me, and many of them initially assumed I was there either to 'help' the researcher with his work (which was focused on working with and speaking with the men who stay in the houses) or to work alongside staff to gain 'experience' for a

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'university placement'. After a few house visits and getting to know different staff members, I realised there was a crucial difference between me and the other 'researchers' and 'students' the staff were used to hosting in the houses. I was there to speak to *staff*, to listen to hear the stories and expertise of *staff* - everyone else who came into the houses as 'researchers' or 'students' were there for the *men or their families. "This is Hazel",* one of the staff members said as she introduced me to one of the men in the house, *"she's here doing research like [Massey team member] is, except she's here talking to staff 'cause she thinks we're important too!"*. I realised this was a new (though differently familiar) experience for the Gandhi Nivas staff and that my presence would have different affects and effects for them than the 'researchers' and 'students' they were used to. Here was another opportunity in my becoming response-able to Gandhi Nivas; staff were responsive, helpful and kind to me, eager to *"get the interview done"* and *"give me what I was looking for"*. But, with a focus on listening to *hear* their stories, and on co-constructing meaning together (to *think with* them), I explained to staff that I would love to spend some time just 'hanging out' with them as they went about their work, to learn what they do and how they do it. Maybe we could do the interview in a couple of weeks, I suggested, after I had a chance to become part of their everyday working lives.

Some staff loved this suggestion and were moved that I wanted to spend more time with them than just the 1-2 hours of an interview, while others were confused; what would I do while I was there? They couldn't ask me to 'work', could they? I explained I was not here to be a hindrance, I was here to help them in any way I could, how else would I learn? As the weeks passed, staff became more familiar with me (and I with them) and I was soon spending at least three days a week in the houses. We would share cups of tea or coffee and conversations like on the first day I met (some of) the Gandhi Nivas team in the offices, swapping stories about our lives, our cultures, our passions and our work. Sometimes these cups of tea or coffee and conversations would be shared with the men in the houses, or their families when we went on home visits. Sometimes the cups would be portable as we headed out into the community with the men to attend to the needs of their everyday lives (taking them to the supermarket, to appointments, to pick up clothes or medicine) or sometimes with other staff members as we attended to the needs of the houses (plants for the garden, milk for the fridge, cleaning products for the bathroom). Indeed, sometimes the cups were left to go cold on the desk as we attended to the needs the

men and their families, the house, or the requirements of running a community service.

I remember a particular day at one of the houses; a staff member and I had been puzzled by a strange smell that was coming from the kitchen. We had noticed it for the last few weeks on every shift we shared and had formed a routine of searching the house to find 'the smell'. On this day, we had decided the likely culprit producing the smell was behind the fridge, but we couldn't quite figure out how to get the fridge out from its nested cubby. I lay down on the floor of the kitchen to try and see underneath the fridge, and indeed, I could see something! Together the staff member and I started to pull the fridge out when another staff member walked into the kitchen. There I was, a 'researcher' who the staff had begun to call the 'psychology expert from the university', lying on the floor of the kitchen and pulling out a fridge to clean up an old smell. *"Oh my goodness, you don't have to do that, that's OUR mess"* the staff member who had just entered said. *"I'm here to help, remember"*, I responded, and he smiled at me and jumped in to help us pull out the fridge.

It was in these moments, the moments that seemingly had nothing to do with 'mental health' and 'domestic violence' crises, that I felt connections to the Gandhi Nivas staff, and it was in these moments that I was learning how to hear the stories they would share with me. I realised that these were not *houses-where-people-provided-a-service* like I had initially expected, but they were *homes* where the Gandhi Nivas whānau provided care, and caring for the men and their families also meant caring for the physical houses, gardens and surrounding community. I would ask questions as we would go about this care work to try and make sense of how the Gandhi Nivas staff saw their actions; by the time I was lying on the floor of the kitchen pulling out the fridge, I recognised this as a caring process too. Caring for the house cared for the men and their families, cared for the staff, and cared for my relationship with Gandhi Nivas as I became response-able with them to the precarious conditions of everyday lives within their community and the challenges of living within patriarchal forms of social entrapment. Becoming response-able with staff helped me *think with* them to increase the adequacy of my understandings. These processes were the *"opening of spaces for dialogue where the meaning being produced as knowledge is co-constructed"* (Coombes et al., 2016, p.447). For example, some staff would tell me they did not know what 'expertise' they had to

offer about the crises of 'mental health'; they told me they were not 'mental health experts' and that their only job regarding 'mental health crises' was to refer on to the 'experts'. With an opportunity to reflect within the research team, I realised staff were helping me hear them as they told me their concerns. I connected their attention to their 'lack of expertise' with Hydén's (2013) discussions about *"the gap between experiencing and knowing"* (p.12). Though the staff spent their everyday working *experiences* responding to 'mental health crises', the way in which their understandings of the intersection of these crises with 'domestic violence' informed their work practices did not have the status of legitimate knowledge of safety enhancing community response-abilities at that location. Thinking with Hydén, I recognised my response-ability as a researcher to reposition the staff as *knowers* in our interactions, *knowers* **because** of their experiences. This helped me reconsider the kind of questions I might ask, changing the questions as a response-able response to staff and opening a relationally safe space between us.

At the end of a shift through which a staff member had started to share stories with me, I would usually bring up the information sheet for my research project again. I would explain to the staff member I had been learning a lot from them lately and I would really love to discuss the intersecting crises further in an 'official interview' – would they mind reading the information sheet (again) and thinking over the decision to participate? I would intentionally leave this to the end of the shift as we were saying farewell, so the staff member had the time to process and think through their decision before meeting with me again. For me, this was key to my focus on relational ethics, but it also attended to the institutional requirements of informed consent. Through processes of 'hanging out', listening to informal stories and having casual conversations, I could attend to consent as *"an ongoing process that does not start and finish with the consent form"* (Hydén, 2013, p.7). These processes were also part of co-constructing knowledge together and sharing the control and ownership of the research with the community, drawn from the principles and values of Community Psychology approaches (e.g. Collie et al., 2010; Hodgetts et al., 2013; Quayle et al., 2016).

After about seven weeks of 'hanging out' in the Gandhi Nivas homes, staff and I began engaging in the 'official interviews'. My interviewing processes were informed by Braidotti's (2019a) focus on thinking as a relational activity and Hydén's (2013) understanding of interviewing as a relational practice. My formal

conversations with staff were informed in and through my everyday engagement with the team, enabling my response-ability to them. Once staff had been in contact to confirm they had read and understood the information sheet and would like to participate, I would arrange interview times with individual staff members, and show up to the houses with my paperwork, tape recorder and home-made refreshments. Often the planned interview time would pass us by as we were immersed in the everyday care work and service provision of Gandhi Nivas. I realised early on the need to become flexible with 'where' and 'when' the interviews would take place; this meant that while some of them took place sitting comfortably in the office and uninterrupted, others occurred 'on the go' as we went about the daily activities of the houses. I would turn the tape recorder on and off when consented to by the individual participant, though we would always make sure we were in a safe and private place before doing so. I connect here with Pita King's (2019) mobile ethnographic approaches where *"participation and simply going along with participants"* enables a broadening of a researcher's vantage point as they experience the everyday lives of participants and the social structures in which these lives are lived (p.111). The *going along* with Gandhi Nivas staff contributed to enabling a hearing of their *stories that tell stories* and was an important strategy for learning to *think with* them and their situated knowledges.

As I had explained to staff, there was not a list of questions I was going to be reading off when we talked, and I was not *"looking for"* anything in particular because what I could see from my vantage point would not be the same as what they could see from theirs. Instead, I would start with *a* question to begin a conversation (or to continue one we had started earlier, informally): *"Can you tell me about your experiences of responding to mental health and domestic violence crises in your work here at Gandhi Nivas?"*

For some participants, this opening question was the only one they needed to start sharing stories with me, officially, 'on the record'. As they talked and I would listen to hear, I would bring the memories of the last seven weeks and 'hanging out' in the homes with me. The memories helped me *hear* what the staff were referring to when they used terms like "intake assessment" or "the system" (understandings that will be expanded on in the next chapter) rather than assuming that those terms meant the same thing to those who work with the messiness of responses in the gaps of service provision through the Gandhi Nivas homes and in their community

relationships, as the terms did to me in the psychology discipline and with my memories of April. When I heard terms or stories I had not experienced before with the participants, I would ask them to *"tell me more"* and I would ask clarifying questions (*"so is that why you did X, Y and Z yesterday?"*). In these interviews I felt comfortable in the ways I was attending to my response-abilities as I'd seemed to find a way to privilege the participants' knowledge and to *hear it*.

With other participants, I found the process more challenging. I recognised that although I had been 'hanging out' in the houses with them as part of their everyday working lives in the community, some staff still focused on the "*culturally highly valued position*" I held as a 'researcher' (Hydén, 2013, p.13) and they privileged respect and care for the institution I was a part of, suggesting that I was the 'expert' and they wanted to 'help' me by giving me *"what I needed"*. I wanted to attend to the care and respect they were showing me and the institution, while still privileging their situated knowledge and their *stories that told stories*. I recognised the *"dance of balancing involvement"* we were doing, where I needed to give more of myself and the expertise of the institution I was part of to navigate a relationally safe space for these participants, differently (Hydén, 2013, p.8). Often this meant I started off the interview by asking more questions in different ways and by bringing in the expertise I represented for these participants, asking questions such as *"In the literature I have noticed X, Y and Z, can you tell me if that's something you've experienced?"*. Sometimes I deferred back to their knowledge: *"I noticed yesterday with a client you did X, Y and Z, can you tell me more about that?"*. As we danced through these interviews, I had to be careful not to give 'too much' of my vantage point, concerned it would dis-able my hearing abilities, but I also had to give 'enough' so that the participants felt like they could share their vantage point with me too.

After the 'official interview' had come to an end and the tape recorder had been turned off, I would stay and 'hang out' with the staff for at least a couple more hours. Sometimes we would cook dinner together (and with the men) for everyone in the house, other times we would head off on home visits or errand runs. Our conversations would continue over the daily activities and continuing to 'hang out' with the participants after the 'official interview' was over meant that I could continue learning to *hear* the stories they had just shared with me and to *think with* them. I would also return and continue 'hanging out' with staff on their shifts, even

though the 'official interview' was done. The staff knew I would be transcribing the interviews and I had given them the opportunity to receive the transcripts and adjust them before signing the transcript release form which gave me permission to use their words in my work. However, I had (now) attended to the realities of their everyday working lives and realised the assumption that a staff member would have time to read through 50-70 pages worth of a transcribed interview was unrealistic, given how busy the houses were and the demands of 24/7 caring work. They had all signed the transcript release forms at the same time as the consent forms, saying *"I trust you, I don't need to read through it again"*. I appreciated and was honoured by the trust, but I also recognised the possibilities of imposing my own vantage point over the participants' knowledge if I had only listened, rather than *heard* them (Waitere & Johnson, 2009). Continuing to 'hang out' after the close of the 'official interview' meant that I could continue to check my understandings and what I (thought I) was hearing against their situated knowledge and the experience of their everyday working lives. This expanded my response-abilities as a researcher as I continued to meet with, speak with and think with different staff members and their perspectives; staff enabled me to open up new spaces for myself to be able to respond as a researcher in their setting, transforming my research practice and increasing the adequacy of my understandings (an experience of joy).

On August 17th, 2021, Aotearoa New Zealand was placed into a Level 4 Alert Level restriction in response to the arrival of the COVID-19 Delta variant (Unite Against COVID-19, 2021). While Gandhi Nivas was an essential service that would keep working through the Level 4 restrictions with strict health and safety processes in place, as a 'researcher' I had to suspend any face-to-face research activities immediately. By this stage of my research, I had conducted five 'official interviews' with staff, ranging between 45-95 minutes in length. I had also spent time with many other staff members informally who had not chosen to come 'on the record' yet. I had been planning to start speaking with Gandhi Nivas police officers in September, as we had decided on the day I first met (some of the) Gandhi Nivas team. As the days of COVID-19 Alert Level restrictions in Tāmaki Makaurau turned into months, I realised the need to revisit the original plan and to pivot to continue to respond to the needs of the community. A decision was made to separate the discussions I was planning to have with police from the work I had been doing with the team in the houses of peace; this meant I could proceed with an analysis of the formal interviews

and ethnography work I had participated in thus far and could offer the community some form of feedback within the original agreed upon timeframe of the study (by February 2022). It is this analysis that I offer in the following pages of my cartography. I will continue the work with the police and ethnography work in the houses when it is safe to do so, as I am response-able to the Gandhi Nivas community and have committed to hearing the police's knowledge too.

Thinking with - in isolation: an encounter with ethics of care

I had transcribed each interview within the 24 hours directly after, so by the time the COVID-19 Alert Level shifts came in August marking the start of my analysis period, though I was in physical isolation, I was also surrounded by stories and memories from my times with Gandhi Nivas staff. Initially, I thought the disruption to my 'hanging out' at the houses of peace would also disrupt the co-construction of knowledge with staff and reproduce the flow of social power relations that situate me as a researcher as the one to know and the participants as the ones to be known about (Coombes et al., 2016; Roberston & Masters-Awatere, 2007). However, as I brought the memories of my time and movement at Gandhi Nivas together with the transcripts of the 'official interviews', I recognised the reciprocity of our relationship did not depend on my physical presence and I could *think with* staff through these memories and stories even if I could not *be with* them. Immersed in the transcripts I started to attend to the similarities and differences I could hear in the stories participants had shared with me and what I had read in the literature, reading from a location (now) of shared *experience* as knowledge situated elsewhere in the community of Gandhi Nivas. As I was reading and *thinking with* Gandhi Nivas staff, I was also remembering April and a cartographer's method of *"creative repetitions i.e. retelling, reconfiguring and revisiting the concept, phenomenon, event or location from different angles"* (Braidotti, 2010, p.412). In subsequent readings of the transcripts, I started to follow the storylines that would enable a different telling of April's story.

As I thought with Gandhi Nivas staff and with April, I noticed an *intangible felt missing* from the stories in the literature when I sat with April and when I was 'hanging out' at the houses of peace. I spent many supervision sessions saying, *"I don't know how to explain it"* or *"what happens at Gandhi Nivas cannot be put into words"*. I tried to explain the 'tasks' that made up the processes of care I witnessed,

felt, received, gave and participated in during my immersive ethnographic experience at the houses, but something continued to be *missing* from my abilities of articulation. As I struggled with an *intangible felt missing*, I (re)connected with Carol Gilligan's (1977; 1986; 1995; 2014) work on morality, and the *intangible felt missing* I noticed began to make sense.

Carol Gilligan began her career as a developmental psychologist, mentored by a leading figure in the field, Lawrence Kohlberg, with whom she disagreed because of the universality of his theories of justice and moral development. From her own experiences and her ethnographic work with her students and research participants, Carol suggested that Kohlberg and the field of psychology offered not a universal understanding of 'human' experiences, but *a voice*, *a* perspective, that was focused on human beings as *individual* persons. I connect her focus and concern regarding this voice privileging the *individual* with the story I told through my literature review, where complex social problems are individualised into issues of personal response-ability in expertise situated in (culturally specific) psy-knowledge claims. Gilligan had recognised the situated character of *a voice* offered by psychology as an ethics of justice privileging bounded individuals based on empirical evidence solely from men and boys. In 1977 she offered the field of psychology *a different voice* that privileged a relational *ethics of care* in human experience.

Gilligan now writes of her *feminist ethics of care* as that which recognises humans as *"responsive, relational beings, born with a voice and with the desire to live in relationships"* (2014, p.90). She explains that although her *different voice* has been offered by women, it is *a(*nother) voice; not *the-universal-voice-of-women* but *a-different-voice-that-was-(also)-the-voice-of-(some)-women*. Recognising a relational ontological understanding of beings privileged in her *different voice* connects Gilligan with Braidotti's (2010) *"cultivation of affirmative relations"* (p.413) and thinking as a relational activity that always involves a 'we'. Haraway (2016) is here too as she agrees that the *"human exceptionalism and bounded individualism"* privileged in Western thought are becoming *"unthinkable: not available to think with"* (p.30).

Thinking with Gilligan, Braidotti and Haraway then, I understand the separation of Kohlberg's 'justice' and Gilligan's 'care' not as opposing orientations but as processes in flow; interdependent and connected. My understanding is

supported by Gilligan and Attanucci's (1988) suggestion that there are *"two intersecting dimensions of equality and attachment [that] characterise all forms of human relationship"* (p.225), where equality reflects an ethics of justice and attachment an ethics of care. However, as the authors explain, within a system of (patriarchal, neoliberal and colonial) hierarchy, justice is often privileged over an ethics of care through patriarchal gender codes of masculinity and femininity in social power relations (my reading). Or in other words, a masculine independent voice is legitimated as expertise while a feminine interdependent voice is recognised as *lesser-than-expertise*. Located in my reading of the 'mental health' and 'domestic violence' crises literature and having noticed the *"bounded individualism"* (Haraway, 2016, p.30) privileged by (culturally specific) psy-expertise, I recognise Gilligan and Attanucci's explanation as sensible. I also remember my day with April and how the system responses I was part of could not *hear* her voice, which I now understand not as feminine and lesser-than-expertise, but as *a*(nother) voice of situated knowledge through an ethics of care.

Recognising Gilligan's (1977) offering as *a-different-voice-that-was-(also)-the-voice-of-(some)-women* and not *the-universal-voice-of-women* allows me to (re)connect with further *different voices* from wāhine Māori scholarship that recognise knowledge production, scholarship and research as deeply embedded within ongoing imperial and colonial practices (Mikaere, 2011; Smith, 2012). I think with Linda Tuhiwai Smith (2012) again to help me remember that:

> *imperialism and colonialism brought complete disorder to colonised peoples, disconnecting them from their own social histories, their landscapes, their languages, their social relations and their own ways of thinking, feeling and interacting with the world* (p.29).

In Aotearoa, as in other colonised countries, research was integral to the processes of colonisation as it determined what counted as 'legitimate' knowledge (and what did not). Indigenous ways of knowing, such as mātauranga Māori, were excluded, marginalised, delegitimated and ignored. Connecting with Smith helps me (try to) avoid unethical and violent practices of reclaiming indigenous knowledges as new 'discoveries' of Western scholars; although there are connections between Western critical approaches (such as Braidotti's nomadic process ontology, Haraway's response-abilities and Gilligan's feminist ethics of care) and indigenous

world views, these are not *the same*, and these Western critical approaches are not new perspectives or debates for indigenous peoples (Smith, 2012). Acknowledging the legitimacy and whakapapa of indigenous ways of knowing is part of my ethical response-abilities in my location in the psychology discipline within a Western academic institution. It also connects to Braidotti's (2019a) question of who 'we' are when considering thinking as a relational activity and opens spaces to recognise another 'missing people'. I re-emphasise that indigenous ways of knowing are 'missing' from the powers of discursive representation (Braidotti, 2010) where the emphasis remains on Western scholars to enable conditions for a hearing (Waitere & Johnson, 2009), rather than a suggestion that there is some kind of 'discovery' of 'a peoples' that needs to take place.

From here, I (re)connect to Mikaere's (2011) work, which recognises tikanga Māori as the first law of Aotearoa, a law that was in place and served the needs of tangata whenua for a thousand years before the arrival of the colonisers. Mikaere (2011) explains:

> *The principles that underpin tikanga are timeless, reminding us that relationships are of paramount importance: relationships between humans and the spiritual relam, relationships between humans and all other living things, relationships between the generations now living and between ourselves and past and future generations as well* (p.243)

A key principle underpinning tikanga Māori is *whakapapa* which centres relationships and focuses on the importance of nurturing relationships as a starting point for living and dying in this world (Mikaere, 2011; Smith, 2012). However, through ongoing processes of colonisation (and the imposition of a patriarchal social structure), the interconnectedness and interdependence inherent in tikanga Māori have been violently attacked and delegitimised in the name of Western hierarchical philosophies of independence and progress (Mikaere, 2011; Smith, 2012). I notice the connections between the focus of indigenous scholars on the processes of research and knowledge production as ongoing processes of colonisation that are disrupting social harmony by ignoring their voices, and Gilligan's recognition that the discipline of psychology was used to performances of (independent, justice-orientated) soliloquies (*a voice*). Here I re-emphasise Gilligan's (2014) focus on *"care as a feminist, not feminine ethic"* (p.30) where she understands feminism as a

project that aims to dismantle patriarchal structures in the name of democracy which requires an equal hearing of all voices. Though I think with Smith (2012) again to remain concerned about claims for equal voice through democratic processes (equal to whom or what, and who decides?), the connections between voices *missing* from our discipline recognises the imposition of patriarchy as a social system that codes *voices*, male or female (or otherwise), into *a* (single, masculine) *voice* (Gilligan, 2014) – the *"bounded individualism"* that is becoming increasingly *"unthinkable – not available to think with"* (Haraway, 2016, p.30).

Bringing together Gilligan (1977; 1986; 2014), Mikaere (2011), Smith (2012), Braidotti (2010; 2019a) and Haraway (1988; 2016) to *think with* me, my struggles for sufficient articulation for what I *felt* and experienced in the Gandhi Nivas houses, and on my day with April, made more sense; the focus on relationships as a fundamental feature of what it means to live *with* others has, at the very least, been written out of Western psychological and philosophical scholarship that has been the predominant focus of my education in Western academic institutions. I am reminded here by Smith (2012) that it was not just indigenous peoples who were subjugated by colonial and imperial powers, as settler Europeans (whose movement has enabled my location as tangata Tiriti) *"had to be kept under control, in service to the greater imperial enterprise"* (p. 24).

Situated in this increased adequacy of understandings, I engaged in multiple readings of the stories (and the echoes of the multiple alongside conversations). Through this immersive process, I used April's storyline to help me map the flow of social power relations that shape the stories and experiences of Gandhi Nivas staff with their clients and to privilege the *different voices* that I had not recognised in the clinical and academic literature. I do this to further increase the adequacy of our understandings (an experience of joy) as I *retell, reconfigure and revisit* April's story from a different location (Braidotti, 2010). The figure I sketched through the literature review of *'a risk to be managed'* comes too and helps me map power as potestas – *"what we are ceasing to be"* (Braidotti, 2019a, p.37). By enabling the conditions to **hear** and think with *different voices*, the voices of April and the Gandhi Nivas participants, I seek to also follow the flows of power as potentia – *"what we are in the process of becoming"* (Braidotti, 2019a, p.37). Through this process I attend to my response-abilities to the Gandhi Nivas community, as I recognise what

kinds of support they need (and from who) to increase our abilities to respond (ethically) to the two crises of 'mental health' and 'domestic violence'.

My analysis weaves together my memories from my day with April, from my thesis journal (my ethnographic experiences in the houses of peace) and from my connections, relationships and conversations with Gandhi Nivas staff. It traces the difficulties of hearing *a different voice* and recognises the dominance of *a voice* from the psy-expertise, the same voice I traced in my literature review[11]. However, a reader will note that *a different voice* **is** present in these stories, and it is this *different voice* that we follow through the analysis too. Tracing both voices enables *thinking with* the Gandhi Nivas community about their experiences of their everyday working lives when responding to the *both/and* crises of 'mental health' **and** 'domestic violence'. As I learn to think with the Gandhi Nivas community, my analysis helps me become response-able to April and my dis-abilities when responding to her on the day we shared, as well as becoming response-able to the Gandhi Nivas community as a researcher. I share the revisiting and reconfiguring of April's story with the academic and psychological communities to offer *"an increase in their power to act, which is experienced as joy and the renewed desire to go on knowing more and better"* (Braidotti, 2019a, p.131).

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[11] Thinking with Braidotti (2011), the dominant voice present throughout my literature review could be understood through a majoritarian position, and the voices present in my analysis through minoritarian positions. However, Braidotti teaches me the importance of surpassing the *"logic of reversibility"* (p.43) and the need to overcome the dialectic of majority/minority, which informs my decisions to recognise the multiplicity and plurality of voices outside of these (temptingly categorical) expressions.

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CHAPTER FOUR: *An* analysis….

We begin, again…

> ### *I met April several years ago in my local police station.*
>
> I met Gandhi Nivas staff, men and their families, anywhere *but* a police station. I met them in the houses of peace, in the supermarket, dairies, the garden centre, in family homes, social services offices, in airports, in a refugee resettlement centre and in pharmacies. Not once did I meet them in a police station.
>
> ### *I was there in a volunteer capacity to support 'victims' of crime, and April was categorised as such that day.*
>
> I 'hung out' with Gandhi Nivas staff in a volunteer-researcher capacity to learn to think with and support staff, the families they work with and for, and the community that welcomed me. Staff at Gandhi Nivas include registered social workers and counsellors, as well as support staff and volunteers. While police reports provide categorisations that suggest the men at Gandhi Nivas are 'perpetrators' or 'primary aggressors' and their families are 'victims' (the persistence of the figure of *'a risk to be managed'*), these are not words that are used by the Gandhi Nivas community. Or (now) by me.
>
> ### *As April told me her story, one of the police officers interrupted us.*
>
> Once a family's experience is categorised by 'the system' as a 'domestic violence' crisis rather than 'mental health', it becomes the territory of the police. However, in South and West Auckland, police are authorised to provide a safety response outside of the criminal justice system by offering the men temporary accommodation and support from Gandhi Nivas.
>
> ### *April had denied the help of the police, as they could only offer her legislative instruments that would criminalise her partner for his actions.*
>
> At Gandhi Nivas, men who enact patterns of harm (like April's partner) are brought into view and their need for help and support is attended to. Rather than a legislative response that criminalises the men's actions without attending to the conditions of their everyday lives or their needs for *"help"* and *"support"*, the

men are offered a *home* to stay in and support navigating their precarious daily lives. The temporary accommodation also provides 'a break' for their families (like April) while the men are cared for by the Gandhi Nivas staff. During this 'break', the families' social and safety support needs are (also) heard and responded to by staff.

As April and her partner left the police station that day, I was troubled. I worried about April, I worried about her partner. I wondered if April or her partner would become 'just another statistic' in domestic violence or suicide reporting, and I worried about my complicity as a service provider if that were to be the case.

A relationship begins between staff and families when the men enter Gandhi Nivas for their temporary stay. These processes of engagement (often) continue far beyond the man's discharge from the house of peace. As the families navigate the complex 'system', they have company, they are a 'we': Gandhi Nivas is with them too.

A focus on relationships and trust moves the figure of 'a risk to be managed'

An other-wise becoming for April's partner

As I traced through my literature review, the social power relations produce a figure of *'a risk to be managed'* where the 'risk' is understood to be *either* a 'mental health crisis' *or* a 'domestic violence crisis'. The 'risk' of 'domestic violence' is managed by police officers, who are authorised to provide an alternative response to criminalisation by bringing men to Gandhi Nivas. However, many staff suggested to me that in the houses of peace they were often working with men who presented with a convergence of the two crises, as April's partner had on the day I am remembering. Participant five suggested: *"I think in my job, most of the times [mental health crises are involved], you know?"*. Interestingly, I did not recognise the figure of *'a risk to be managed'* (either/or) initially in my visits to the houses of peace. At first it was difficult to tell which of the men there were clients. The houses are busy places with many comings and goings. On a typical visit to the house, it would not be unusual to meet staff, community members, police officers, people who do the house maintenance, clients, staff from community service organisations, students and researchers all flowing in and out of the whare[12]. While some of these individuals were more easily distinguishable than others (it was hard to ignore the uniform of the police officers, for example), each person who entered the door was greeted with the same welcoming smile and offer of a cup of tea – usually from the first person who saw them. I sometimes became this person, as I became more familiar with the location of the cups and tea, and more familiar with myself in these spaces.

Staff would tell me how much that smile and cup of tea made a difference for the men who did walk through the door as clients. They would tell me (and I would experience with them) how men would often be brought to the houses very distressed, and staff would focus on building relationship with their new client first and foremost. Despite staff having a lengthy assessment form to complete for each

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[12] The word 'whare' appears throughout this analysis as a memory; Gandhi Nivas staff do not call the buildings in which they work either houses or services. Instead, they often use the te reo Māori term 'whare'. The *intangible felt missing* matters here as I do not feel that 'house' or 'meeting place' is an adequate translation for what 'whare' represents for the staff, and so the use of 'whare' is two-fold; as a memory of my time in the Gandhi Nivas whare (houses of peace), and as a reminder of *different voices* of expertise and connections they share (Gandhi Nivas with tangata whenua)

intake (more on this soon), leading with a focus on relationships and care for the men often means letting them go straight to bed to sleep or sitting with them for hours and holding space for them to cry. Often a relationship began by an offer of food, as the cupboards were always full of basic groceries and men were often hungry. I recognised sharing food with the men as a respectful process of relationship building and attending to some of the precarity of the men's everyday lives.

Participant five shared with me a story about a client who had stayed with them on multiple occasions and had refused to speak a single word during any of his stays at the house. She had navigated multiple strategies across his visits to try and encourage him to converse with her, but he refused. One day, participant five had gone to a shared lunch event before work and decided to bring the leftover treats from the lunch to the house for the men:

> *"So I just went inside and said "here's some food" and he just smiled. And I just remember that wonderful smile…But he didn't talk okay, but at least he would smile…and then one day he came and knocked on the office just to ask for a towel…one or two words here and there…"* – P5

Through her processes of care by bringing food for the man even though he did not appear to be engaging with her, participant five connected with the figure of *'a risk to be managed'* in a way that demonstrated he mattered to her, and she was there to support him. I saw these processes of care lead many interactions in the Gandhi Nivas whare – whoever walks through the doors is greeted first and foremost for their potential, not as the figure of *'a risk to be managed'* as designated by the system responses. The men are greeted as *"responsive, relational beings, born with a voice and a desire to live in relationships"* (Gilligan, 2014, p. 90). Staff would tell me that because police officers (most often) bring the men to the whare, men would think they were being *"put in a cell"* (P4). Through an offer of a bed, food or a space to cry, the assumption of a *"cell"* is challenged as the men are *welcomed* into a *home* and the beginning of a relationship. I began to understand this welcoming and the connections to the figure of *'a risk to be managed'* as a relational ethics of care flowing through the Gandhi Nivas staff.

I broaden my understanding of the relational ethics of care flowing through the Gandhi Nivas staff by connecting to Mikaere's (2011) discussions of tapu in Te Ao Māori. Mikaere explains tapu has two major aspects: the first is spiritual

prohibition or protection. The second, which is often missed or misunderstood by non-Māori she explains, is regarding:

> *"the recognition of the inherent value of each individual, the sacredness of each life. No individual stands alone; through the tapu of whakapapa she or he is linked to other members of the whānau, hapū and iwi, and to other Māori as well"* (Mikaere, 2011, p.196).

Thinking with Gilligan (2014) and Mikaere (2011) helps me understand the acknowledgement of the potentia – *"what we are in the process of becoming"* (Braidotti, 2019b, p.37) and interconnectedness of each life that walks through the door of the Gandhi Nivas whare. I notice how the acknowledgement of potentia by staff moves the figure of a man who is *'a risk to be managed'* and enables otherwise connections. While the man's enactment of patterns of harm that brought him into the whare is not entirely forgotten (indeed the figure is still there – more on this soon), it is what he is *"in the process of becoming"* (Braidotti, 2019b, p.37) that the Gandhi Nivas staff focus on. Building relationships through the *"recognition of the inherent value of each individual"* (Mikaere, 2011, p.196), the man's 'risk' that has brought him into the whare becomes permissible to talk about, as he begins to trust the staff. Participant four explains:

> *"These men, they don't trust, they don't trust anybody out there. So how are they supposed to just come in here, trust us and start spilling everything? And we just need to give them time. Sometimes they'll talk about everything else under the sun except what they are supposed to be talking about. And we just humour them, we're just like "yeah yeah okay, tell me about this". And when they are convinced that "okay, this is somebody who really, not judging me, they are really there to support me, they are there because they want to help me", that's when they open up. And I don't blame them for that because they're out there, they can't trust anybody out there."* – P4

Participant four speaks about letting the men talk about *"everything under the sun except what they are supposed to be talking about"* and indeed, I saw many staff do this (and began to do it myself). When welcoming new clients to the whare, staff would ask them to settle in and then come and find them for 'a chat' or 'a catch up'. Staff had explained to me (and shown me) the comprehensive assessment form they had to fill out for each new intake, and I understood this 'chat' to be about this

assessment form. The assessment form (from my location as a service provider, remembering my day with April) looked standard to me: personal details, physical and mental health history, previous criminal history, gang affiliations, emergency contact and a needs assessment for social support. But this assessment form was often not present during 'catch ups' with men, and its questions did not lead conversations. As I recall one staff member saying to me over a shift, *"it's a conversation that fills in paperwork, rather than paperwork which fills in a conversation"*. Often these conversations with men would last for hours and would involve the use of many languages. Despite staff often introducing me to the men as *"smart"* because I was *"the expert"* from *"the university",* I often felt the one most lacking expertise; on any given day I could be listening to more than seven different languages and both the men and the staff would swap in and out of English for my benefit to connect me into the flow of their everyday lives. Both staff and men had to spend time explaining concepts and histories from their cultures that I was unaware of, and I recognised these *different voices* as further forms of expertise *missing* from psy-knowledge, as well as the care taken by my hosts to bring me into the cultural nuances and interactions of the whare. The men would share stories of their journeys with staff and would often laugh and cry. We would share stories and laugh and cry with them. When a man left a conversation with a staff member, I noticed staff would start filling in the assessment form with the information they had just learnt. This assessment would be updated by every staff member after every communication with a client or one of their family members; as the figure of *'a risk to be managed'* moved and transformed the risk assessment space through connections with staff, staff's response-abilities strengthened as they could understand the ways they could respond helpfully to support men and their families.

Staff understood that men may communicate in ways outside of normative frameworks of understanding and would engage with any kind of communication offered to them to the best of their abilities. The *"wonderful smile"* remembered by participant five earlier is just one example; I recall another time I was spending a shift with a staff member and we engaged in a conversation with a client who was telling us about his spiritual powers. Sometimes this client appeared to be communicating with others who we (the staff member and I) could not see. We listened to this man talk and asked him to *"tell us more"* about his spiritual powers; not with an assessment form in our hands or a judging 'expert' eye, but over a cup of

tea with him, 'a catch up'. I reflect now on the similarities between these kinds of exchanges between staff and the men, and my interviewing processes as a 'researcher' with research 'participants' – the attempt to disrupt the hierarchy of social power relations and attend to (and think with) the expertise of the person and their vantage point. The man showed us pages of notes he had made in his room when he had *"received an influx of knowledge"* (his words) earlier that night, and he talked us through the notes and the lessons he had just learnt. From my location in the psy-assemblages, dominant assumptions and terminology related to mental illness arose for me as I listened to him talk. While I acknowledged those assumptions, I did not focus on them or allow them to lead my interaction with him. Rather, I focused on the relationship we were building. Participant three explains taking time to listen to the men in their difference is an important part of relationship building:

> *"They want to talk but um, what they are saying actually does not make sense sometimes. But they still want to talk to you. That's their way of saying, "you know, I like this place""* – P3

Here Participant 3 recognises a man who *"does not make sense sometimes"* as someone trying to communicate and *"cultivat[e] affirmative relations"* with staff (Braidotti, 2010, p.413). Instead of focusing on (either/or) *'risk to be managed'* that brings the men into the whare, the staff begin with where the men are willing or able to communicate from. Beginning with the men (instead of the 'risk' or the assessment form) also enables a more comprehensive picture to be built by staff of the men's (and families') needs, as men would share details through their storytelling that would become relevant to their needs assessment. These details would be shared on the men's terms; volunteered through ordinary everyday conversations with staff members, rather than in the context of an official 'assessment'. As I learnt to begin with the men (with Gandhi Nivas staff), I (re)connected to Michelle Brown's (2013) suggestion that the way out of the Society-of-Captives is by listening to pain for real for *possibilities* to *materialise*. Beginning with an acknowledgement of structural violence without the need to responsibilise the individual for that violence (Brown, 2013) transforms the conditions to enable the hearing of *different voices*, challenging the soliloquies of psy-expertise (Gilligan, 2014) and the exclusionary category of the 'human' (Braidotti, 2010) to enable attention to the men's potentia (Braidotti, 2019a).

Possibilities would *materialise* through conversations at Gandhi Nivas; as the men would start to know and trust the Gandhi Nivas staff (and me), they would continue to volunteer information that could inform the staff's needs assessments and help develop a comprehensive support plan. This did not mean ignoring the men's signals of psychological distress or the potential that they posed *"a serious danger"* (MHA, 1992). Instead, this was about *listening to pain for real* to establish trust with these men and understand the extent of their psychological distress in the context of the men's everyday lives. *Listening to pain for real* strengthened staff's response-abilities. Staff understand trust is not easily established for these men, particularly men who have been through various facets of the system response (such as those with diagnosed mental health conditions). The system responses constitute the institutional technologies of power that attempt to *"pathologise, criminalise, demonise or sanitise difference"* and this restriction of human potential is not just externally regulated but becomes internally learned and monitored within a Society-of-Captives (Arrigo, 2013, p.673). For participant two, she understands that men's multiple experiences of fear need to be understood:

> *"When you are working with somebody who is struggling with managing their wellbeing, they're fearful. They're fearful of who they are, they're fearful of who they can be, they're fearful of who they think they can be, they're fearful of when they know that they've been at their worst. And if you feed into that fear, you've lost the person. You can't feed into their fear of just not knowing the unknown, you know? You have to be able to say: "to feel that fear is an achievement. For you to have an understanding 'that fear will drive me to do things that's going to hurt me, hurt my family, hurt my people', that's an achievement. Now that we have that, what are we going to do with it?""* – P2

Participant 2's explanation of not *"feed[ing] into their fear of just not knowing the unknown"* (re)connects me to Szmukler and Rose's (2013) work on risk assessment, where risk assessment is understood as the solution to bringing the unknown future into the present and making it calculable. They suggest this is deemed necessary by dominant narratives that privilege public safety in the context of violent crime which is thought to have been able to be prevented (i.e., by an 'expert' accurately assessing the likelihood of the harm occurring and intervening to stop it). However, as explored in my literature review, there are significant empirical,

statistical and ethical issues with individual risk assessment that mean the ability for practitioners to make accurate predictions about future harm is seriously limited (Coombes & Te Hiwi, 2007; Langan, 2010; Large & Nielssen, 2011; Szmukler & Rose, 2013). Therefore, Szmukler and Rose (2013) suggest the function of risk assessment becomes about allocating blame in a neoliberal society where social problems are individualised and responsibility is attributed according to an individual's conformity (or not) to ways of doing humanness recognised through the lens of sameness or 'normalcy'. They suggest this impacts the therapeutic relationships between staff and clients as interactions are steeped in fear, 'risk' and the allocation of blame. Participant two offers an other-wise response – she discusses *"feel[ing] that fear"* and doing something with it, *listening to pain for real*. Indeed, in a house designated for men who enact patterns of harm, *"feed[ing] into that fear"* (felt by the men) could be understandable. But rather she acknowledges (feels) the fear and asks: *"what are **we** going to do with it?"* (my emphasis). There are no bounded individuals here but a 'we' who might become otherwise through an affirmative relational ethics of care that recognises participant two and the man as interconnected and interdependent beings (Braidotti, 2019a; Gilligan, 2014; Haraway, 2016; Mikaere, 2011).

Recognising the men as interconnected and interdependent beings and *listening to their pain for real* with participant two helps me attend to *affect* – the ability to affect, and be affected by, others (Braidotti, 2008). *Affect* is what connects differentiations of life and sets the tune for the *"the ethics of our interaction"* (Braidotti, 2006a, p. 408). Braidotti (2008) recognises pain as a way to communicate that our *"subjectivity consists of affectivity, inter-relationality and the impact of others"* (p.18) and from here suggests the harm one does to others is *"immediately reflected in the harm you do to yourself"* (Braidotti, 2019a, p.169). Pain is also a way of communicating sustainability: *"how much a body can do"* (Braidotti, 2006b, p.239). Braidotti (2006b) moves the experience of pain outside of the dominant psy-expertise frame of interpretation that recognises it as potential 'symptoms' of 'mental illness' and instead recognises these 'symptoms' as *"corporeal warning signals or boundary markers that express a clear message: "too much!""* (p.239). Gandhi Nivas staff hear the message of *"too much!"*, and by *listening to pain for real* and *feel[ing] the fear* with clients, staff attend to the interconnectedness and interdependence of themselves and the men they work with. As they offer men a chance to *tell more* about

the conditions of their everyday lives, staff acknowledge the call of *"too much!"* as a potential of an alternative (ethical) creative encounter and a possible opening of space in which change can happen – movement towards becoming other-wise. In doing so, they are attending to the response-abilities they have as interconnected and interdependent living bodies – bodies that have not reached the threshold of sustainability and therefore are *able* to *respond,* ethically.

Had April's partner been offered by police officers to come to Gandhi Nivas, and had he accepted the offer to be welcomed into the whare and to express his message of *"too much!"*, it is possible that he may have immediately received the *"help"* and *"support"* April suggested he so desperately needed. He may have received not an offer of *compulsory assessment* and *treatment*, but been *listened to for real* and *responded to* as staff were *able.* Knowing her partner was cared for and supported may have enabled a different response for (and from) April rather than denying the pain she was experiencing and leaving services without any support in place. Next, I trace my understanding of how April may have been cared for by staff from the houses of peace.

An other-wise becoming for April

The acknowledgement of interconnectedness and interdependence through a focus on relationships permeates the whare and moves into the community, as does the care work of Gandhi Nivas. Walking through the doors of the whare initiates processes of care not just for the men, but also their families:

> *"So understanding their needs and the type of the support that they need, and their families. We consider not only the client, but also their families"* – P1

Participant one repeated *"but also their families"* in many different ways throughout our conversations. It was important for him, and the rest of the Gandhi Nivas staff I spent time with, that I heard that staff worked with *families* in the context of their everyday lives to understand how staff could provide *families* with care and support. In the *going along* with participants (King, 2019) to facilitate a hearing, I spent a lot of my ethnographic experience going on 'home visits' with staff members. While the men are staying in the houses of peace, staff take the

opportunity to connect with the family and understand how they have been caring for themselves and the men. Physical visits to the families' houses were an important part of the care work for staff: *"anyone can pick up the phone and ring but taking the time to go to their houses shows we care"*, Participant one told me on a car journey to a family's home. These home visits were often about making an initial connection with families, so staff focused on introducing themselves and the Gandhi Nivas services, explaining where the family's loved one was staying and what support they could provide. Staff would provide contact details for Gandhi Nivas and explain to the families how staff were response-able to them and their loved one. Here I remember sitting in the reception at the police station with April, and her worry and distress as she waited for her partner to be 'assessed'. She wanted to know who was assessing him and what they were planning to do, but she never met the clinicians that met her partner that day. The Gandhi Nivas home visits cared for people like April as people like April cared for their loved ones who were staying in the Gandhi Nivas whare. The home visits would also open a point of connection so family members could join with support in their own time and on their own terms; staff would often leave family homes with *"let us know if you need anything"*. What is *"need[ed]"* is defined by the family (and therefore the meaning of 'family' is open to interpretation) and through *listening to hear pain for real,* staff produce responses with men and their families that are careful and creative.

As Gandhi Nivas is a 24/7 service, the families and the men can be *listened to for real* and *heard* at any time. This was particularly important when responding to the precarious conditions of everyday lives and listening to pain for real (without responsibilising the individual), as often family members had pressures of full-time work, parenting, looking after elderly relatives, undertaking domestic chores, commuting and supporting their loved one who was (now) resident at Gandhi Nivas. The challenging demands of precarious everyday lives were also acknowledged by domestic service providers in the literature as contributing to the challenges of service provision when working with families (Mengo et al., 2020). In the context of these conditions, asking families to commit to specific timeframes (such as within 9-5 working hours) to receive support was understood by Gandhi Nivas staff to be a burden, and staff worked to alleviate this burden as much as possible. I went along with staff as we delivered food parcels to homes, assisted clients (*and their families*) to travel between support agencies and public transport hubs and accompanied

clients and their families to various kinds of social support and medical appointments as their advocates. Staff would also provide counselling at any time suitable to the families, and this was free of charge for any family member who wanted it, including children. Often the first counselling session was not planned or booked but done 'on the spot' in the moment of crisis, with follow up sessions shortly and regularly afterwards. As I was welcomed into some of these impromptu sessions by men and staff, I recognised them as not as assessments or interviews, but as processes of relationship building and connection. These relationships enable staff to care *with* family members such as April *for* the men, attending to calls for *"help"* and *"psychological support"* like on the day I am remembering with her.

I said the care work of Gandhi Nivas often extended beyond the whare and physically this was often the case (as explained above) but it also manifested in other ways too. Staff could hear what (I think) April had been trying to communicate on the day I am remembering – that caring for her partner *was* caring for her. Participant four recalls for me a time she was getting ready to leave work for the day, but a client in the house asked her to stay behind because he needed to talk. She stayed for more than an hour past her shift (beyond midnight) to *listen to (hear) his pain for real.* While she tells me her connection with the man and his manifestations of distress (the call of *"too much!"*) motivated her decision to stay behind, she was also considering his partner's safety:

> *"I was like "okay, just calm down, sit down" and we had a huge chat. He was like "if you wouldn't have [stayed]…I would have gone back home, even with a PSO yesterday…I would have gotten inside the house and I don't know what I would have done"." – P4*

She paused to tell me it was walking distance between the Gandhi Nivas whare and the man's house, so I understood she was caring for his partner's safety:

> *"So we don't know what we would have done. He would have gone back home straight away and bashed her up. She wouldn't have called the cops again, you know? It's those kind of things" – P4*

Participant four explains she stayed behind not just to care for the man but to care for what *could* happen to the man's partner in the absence of care. Her concern for the partner's safety, her relationship with the man and his partner, and her focus

on *"what they are in the process of becoming"* (Braidotti, 2019b, p.37) helped her become response-able to navigate a safety response. I remember my day with April and the dis-ability I felt in the system response. I remember her walking out of the police station having received no *"help"* and *"support"* and my worry and distress that her or her partner may become *'just another statistic'* in mental health or domestic violence reporting. I recognised that April was likely not to call the police again, and participant four acknowledged this was a possible outcome for the partner of the man she was working with too. But participant four *thought different thoughts* than the system I was part of on my day with April; rather than individualising social problems through risk assessment (Langan, 2010) and categories of 'victim' and 'perpetrator' (Stark, 2012), Gandhi Nivas focus on building relationships to meet families in the context of their (precarious) everyday lives. Through these relationships, staff work with and hear families to increase response-abilities (Haraway, 2016) and the adequacy of understandings (Braidotti, 2019a) when navigating a complex system to try and assure safety for all involved.

The support offered to families is not dependent on the men's engagement with Gandhi Nivas services; once the family is referred by police to the houses of peace, the provision of support is unconditional for anyone in the family who wishes to take it up. Here I pause to remember one particular woman's delight that *"someone cares for me too"*. As we stood in the front yard of her home, she explained to us the *"roundabout"* that was her experience of *"the system"* when trying to get support for her partner, her children and herself in the context of their daily life struggles. She understood that her safety was cared for by the temporary removal of her partner from her home, but she expressed immense gratitude as we explained to her Gandhi Nivas was more than a temporary crisis solution for her partner. She recognised Gandhi Nivas staff were offering to become part of her processes of care for herself, her partner and her family regardless of whether they stayed together or not, and regardless of who had come into the view of 'the system' during this particular 'crisis'. I remembered April and wondered where that *"someone"* was who cared for her too. It was me, I realised, but I was not able to do anything within the system I was located in and the understandings it offered me ('victim', 'perpetrator', 'compulsory assessment', 'treatment', 'arrest'). As I realised this, standing with the Gandhi Nivas staff and talking with the woman, the woman confirmed my dis-ability within 'the system' by naming the service provider I had

been working for on my day with April. The woman said she had only ever been offered help once before, by this particular service provider, but she was not interested because they would not work with her partner or children alongside her, and she was concerned about what 'the system' would *do.* The response-ability for the safety of her and her loved ones had been returned to her, just like April. But here was Gandhi Nivas, offering an alternative response to care for her safety, and here was I, alongside them, becoming a 'we' with this woman. I was moved, I was sad (for April and myself), and I was excited for the potentia; the differences Gandhi Nivas makes as I *revisit, retell and reconfigure* April's story.

Caring for boundaries of expertise – an encounter with two more figures….

As relationships are built in and out of the Gandhi Nivas whare, staff attend to the conditions of everyday lives and *listen to (hear) pain for* real. In doing so, they become *able* to hear and *respond* to men and their families. Staff recognise that the figure of *'a risk to be managed'* is *"localised, situated, perspectival and hence immanent to specific conditions"* (Braidotti, 2019a, p. 136), and understanding the *specific conditions* matter for Gandhi Nivas staff when trying to connect with the figure of *'a risk to be managed'* to hear the calls for *"help"* and *"psychological support"*. I reflect again on the similarities between my processes of ethnography and 'hanging out' with 'research participants' to facilitate conditions for a hearing, and the processes of relationship building and care work that I participated in with Gandhi Nivas staff. These relational processes focus on attending to the interdependent and interconnected character of life (Braidotti, 2019a; Mikaere, 2011) and recognise humans as "*responsive, relational beings, born with a voice and a desire to live in relationships*" (Gilligan, 2014, p. 90).

As I would listen to (hear) staff as they would recall listening to (hear) the men, staff would explain to me firmly that the *kaupapa of Gandhi Nivas is family violence **not** mental health*. I would ask them to *"tell me more"* about what they meant by this, and staff would explain that though *"it's never pure family harm"* (P3) and *"they're [mental health and addiction, family violence] are all co-existing…and it's never going to change"* (P2), they were *"not the right people"* (P1; P3) when it came to men who were struggling with 'mental health crises'. The division of my figure of *'a risk to be managed'* in these conversations (between myself and staff) reminded me often of my day with April; *either* 'mental health' *or* 'domestic violence'. Staff explained to me it was a case-by-case basis; if a potential client had a mental health diagnosis but was engaged in services, taking his medication and presenting calmly to the police officers, they would be welcomed into the house of peace. If the police officers had concerns about the man's mental wellness presentation, staff would tell me they would encourage the officers to take the man for a DAO mental health assessment to 'clear' him before staff would welcome him into the whare. Staff told me they would do this in the hopes that the men would get to the 'right' people by meeting with the mental health assessment

team first. As the figure of 'a risk to be managed' is fragmented into *either* a 'mental health' *or* a 'domestic violence' crisis, two other figures persist in appearance.

The figure of the psy-expert

The 'right' people for men experiencing mental health crises, staff would tell me, were the 'mental health experts' or what they helped me see as *the figure of the psy-expert* (more on this 'seeing' of the difference between 'mental health' and 'psy' expertise soon). From my vantage point, the *figure of the psy-expert* was both omnipresent and felt missing in the houses of peace; it seemed to guide interactions through self-policed and externally regulated assumptions of 'normalcy' (Arrigo, 2013) yet I never once physically met a psy-expert during my time at the houses of peace. Instead, I would hear stories about staff and clients *going to* hospital emergency rooms, about Zoom calls with psychiatrists and psychologists, about waiting lists for mental health appointments, visits to GPs for 'sleep medication', and about night psychiatric nurses and support workers who would come to the houses on *'med[ication] runs'*. Sometimes (as I mentioned in passing earlier) staff would recognise me as *'the psy-expert' from 'the university'*; I felt uncomfortable at these times as for me it was a misrecognition. I noticed that when staff spoke about *the psy-expert*, they recognised the expertise of clinical psychology and the language of pathology; the expertise of the (culturally specific, located, perspectival and partial) psy-expert I have drawn through my literature review and have shown reproduces complex social problems as experiences of individual responsibility (Hodgetts & Stole, 2017; NZFVDRC, 2020; Patterson et al., 2018; Rose, 2019) which *"pathologise, criminalise, demonise or sanitise difference"* (Arrigo, 2013, p. 673). At these times, navigating Hydén's (2013) *dance of balancing involvement* was challenging; I wanted to respond with care for the respect staff were showing for *a voice* of the discipline I was part of, but I also wanted to open space to hear their *different voice(s)*.

An opportunity to open such a space was produced as I would bring up the convergence of the two crises to staff in our informal and formal conversations; I noticed something happening I did not expect. While I confidently asked staff to tell me about 'mental health crises', I noticed each staff member stumbling over the phrase 'mental health'. Staff would pause, stop halfway through the phrase or offer other phrases instead, such as *"psychological distress or wellbeing concerns"* (P5),

"struggling with managing their wellbeing" (P2), *"diagnosed mental health issues"* (P3), *"mental health issues"* (P1) or *"has a diagnosis"* (P4). Other terms I heard during my informal conversations in the houses included *"mental wellness concerns"* and *"mental wellbeing concerns"*. When staff did echo the phrase I used back to me ('mental health crises'), I noted a tone of respect when they did so and the privileging of *a (dominant) voice* of (culturally specific) psy-expertise; it would often be followed with a recitation of DSM-5 diagnoses and a list of the assessments used in the whare. I recognised that my phrasing *"mental health crises"* signified a particular figure for staff, and I recognised their stumblings over the term as an opportunity to hear *a different voice.* As I participated in conversations with men and their families, I saw repeatedly what I understood to be manifestations of psychological distress – tears, anxiety, sadness, anger, shame, fear, confusion, hallucinations, panic – and staff worked with these manifestations of psychological distress by *listening to (hear) pain for real* and building relationships of care and trust. These manifestations did not appear to be beyond the supportive capacity for Gandhi Nivas staff, whether the manifestations came with the label of a 'mental health diagnosis' or not, so I wanted to understand where the division was made between a mental wellness concern that staff felt was within their kaupapa and a 'mental health crisis' that staff thought was beyond their boundaries of expertise. As I asked this question in various ways, staff would respond by attending to psy-expertise and normalcy, signalling to me the boundary line where the division lay:

> *"Um…there's a lot of difference. A mental health person does not know what he's doing. A normal, normal person knows what he's doing"* – P3

With participant three's attention to *"normal"*, I return to Arrigo's (2013) Society-of-Captives. Arrigo argues *"humanness is normalised, knowledge about difference is territorialised…and dynamic potential is vanquished"* (p. 673), and it was this territorialisation of difference I was recognising in my conversations with Gandhi Nivas staff. If they could recognise mental distress or wellbeing concerns experienced by a man as *"normal"* within the context of everyday lives, Gandhi Nivas staff felt comfortable in their response-abilities. However, when a suggestion of abnormality was made, staff explained to me this was not their area of expertise and that the man needed support from the 'right' people – *the figure of the psy-expert.* I asked staff to *"tell me more"* about identifying abnormalcy. Many staff would defer (again) to the language of the DSM-V often offered to them via police

reports or from family members. They would also tell me about noticing 'signs' of abnormality, including *"talking alone…showing aggressive behaviour…hallucinating"* (P1), *"talking too much…saying stuff that doesn't make sense…or they won't be talking at all…they'll just be like hiding their face"* (P4). Staff recognised that these presentations could be complicated by men's drug or alcohol use, however they suggested that *"even addiction to alcohol or addiction is a mental health diagnosis at the end of the day, right?"* (P5).

However, staff made it very clear to me that they did not make decisions as to whether someone was 'abnormal' or not. *"We don't judge, we are nobody to say that he has mental health issues"*, participant one explained, as many staff did in similar ways. The decision of (ab)normalcy was for the psychologists and the psychiatrists, they explained, which helped me see the difference between a 'mental health expert' and my *figure of the psy-expert*. As participant four and five explained to me, *"mental health is on a spectrum"* and where a particular client sits on that spectrum determines who should respond. The threshold of normalcy that marked the Gandhi Nivas staff as *"nobody to say that he has mental health issues"* (P1) and psychologists and psychiatrists as 'the experts' was attended to through the (power that manifests in the) knowledge of *the psy-expert*, particularly the DSM-V. Here I (re)connect with Nikolas Rose (2019) as he explains that manuals such as the DSM are like maps that *"mark out, shape and configure a territory for psychiatry to occupy"* (p.73). The territories configured by maps such as the DSM have expanded since deinstitutionalisation and now includes the territory of everyday life. While Rose (2019) is concerned this configuration is increasingly co-opting how mental distress is understood, experienced and responded to in everyday life, Gandhi Nivas staff use their skills to make a delineation between *"psychological distress"* or *"mental wellbeing concerns"* that they are able to respond to, and 'mental health crises' or *"episodes"* (P3) that mark the territory of *the psy-expert*.

Though psy-expertise was privileged in staff's observations, they also used their own knowledge to help make these decisions. This knowledge included being with the men in their daily lives at the houses, as well as specific cultural and spiritual knowledge they (often) shared with the men. For example, staff explained to me that many different cultures revere the ability to see spirits. This meant that when men would tell staff they could see spirits (or someone/thing that staff couldn't see), staff would respond by asking the men to *"tell me more"*. Rather than judging

immediately and assuming the man was a "*mental health person [who] does not know what he's doing*" (P3), staff would explore what seeing a spirit meant for the men and would often ask for the family's expertise too. If it was outside of the expected everyday experiences for the man, staff would recognise this as (potentially) 'abnormal' and therefore the territory for *the psy-expert*. From this recognition, staff start a conversation with the man about his mental health and the potential for getting support, as they recognise his consent is important for him to engage with services.

I pause here to consider the implications of understanding *"a mental health person"* as someone who *"does not know what he's doing"* (P3) in the context of domestic violence, as many staff offered me this kind of explanation across our conversations. Informed by the knowledge of *the psy-expert,* staff made sense of particular manifestations of psychological distress as beyond an individual's control, or that an individual does not realise he is causing harm. I (re)connect here with Julia Tolmie's (2018) work on coercive control, which understands domestic violence not as discrete events but as ongoing patterns of harm in relationships where gendered violence is normalised through patriarchal social power relationships. Tolmie thinks with Evan Stark (2012) who recognises these patterns of coercive control as *"invisible in plain sight"* (p.14); invisible because they are not brought into view when the focus remains on discrete acts of violence. Thinking with Stark leads Tolmie (2018) to ask *"if abusive behaviour exploits existing gender norms, where does 'normal' end and 'abuse' begin?"* (p.56). I wonder about the *"normal person"* and their ability to *"know what he's doing"* (P3) in a patriarchal society that normalises violence through systems and structures of domination and subordination (Gilligan, 2014; Mikaere, 2011). I also remember the literature that demonstrates mental health diagnoses may be used to reduce or absolve men's responsibility for their violence (Coates & Wade, 2004; Hydén, 2013). The territorialisation of knowledge about difference (Arrigo, 2013) in respect to the two crises of 'mental health' and 'domestic violence' seems to contribute to the reproduction of complex social problems as issues of individuals and re-enforces a focus on discrete acts of violence rather than patterns of coercive control. Or in other words, it continues to privilege *a* (masculine, justice-orientated, individual) *voice*.

Recognising the territorialisation of knowledge regarding 'mental health crises' or *"episodes"* that mark the boundaries of *the psy-expert* (re)connects me to

Braidotti's (2019b) attention to advanced cognitive capitalism that *"profits from the scientific and economic understanding of all that lives"* (p.41) as the conditions of everyday lives that 'we' (Gandhi Nivas staff, myself, the psy-assemblages, April) share. For Braidotti (2019b), this type of advanced capitalism *"promotes the quantitative proliferation of multiple options in consumer goods and actively produces deterritorialised differences for the sake of commodification"* (p.41). Thinking with Braidotti, I wondered if it was capitalism's production of "*deterritorialised differences for the sake of commodification"* that had fragmented the crises of 'mental health' and 'domestic violence' on the day I shared with April, and I wondered if that same production was occurring in the houses of peace. I asked staff members how they understood the difference between the work they do and the work *the figure of the psy-expert* does. Many staff would explain to me that *"I'm a counsellor, I've never been taught to deal with a person who's having a mental health episode"* and that *"maybe in a mental health setting they would know exactly what to do"* (P4). Knowledge about responding to a *'mental health crisis'* was not accessible to Gandhi Nivas staff under their professional registrations of social workers and counsellors; that knowledge was the territory of doctors, psychiatrists and psychologists, staff explained.

Within their boundaries of expertise and respecting the institutional hierarchies of practice and knowledge production (the privileging of *a voice),* staff would explain that men experiencing 'mental health episodes' need to be medicated by an 'expert' to become 'normal' again. As participant one suggests: *"when they take medicine they are very, so normal"*. This helped me understand the difference between 'mental health experts' and *the figure of the psy-expert*; I recognised Gandhi Nivas staff as 'mental health experts' as they respond to men and their families who experience mental distress or wellbeing concerns. But it was when staff, using the knowledge of *the psy-expert* (the culturally specific *thoughts that think thoughts* I traced through my literature review), attended to a need for *medication* that I saw the differentiation between 'normal' and 'abnormal' and therefore the boundaries of expertise that formed a figure; those engulfed in *the figure of the psy-expert* include psychiatrists, psychiatric nurses, psychologists and general practitioners.

However, one staff member articulated her understanding of the figure differently; while medication was a paramount concern, her understanding of the difference between her and *the psy-expert* rested in funding constraints and

knowledges that know knowledges. She explained she would take men experiencing 'mental health episodes' to *"a 'psychologist' because they get the funding"* (P2). From her vantage point, the territorialisation of knowledge did not only reflect practical skill gaps but also included resourcing decisions made at government level regarding mental health and domestic violence service responses, and the dominance of psy-expertise in these spaces. She helped me understand that the fragmentation was occurring elsewhere, and that to able to participate in the system to help their clients, Gandhi Nivas needed to participate in the fragmentation too.

So, staff would move for connections with *the psy-expert* when the men (and/or their families) they were working with needed support that was beyond staff's capacity (funding/resource capacity, skill capacity or otherwise). However, decisions to do so were not made lightly, and often involved many 'catch ups' with the men and their families, as well as team meetings among staff members. Gandhi Nivas staff would use their expertise to understand if a referral to *the psy-expert* was appropriate, and how to make the connection safely and carefully. I reflected on my day with April and noticed the connections between her expertise (noticing her partner was not safe and trying to connect him to *the psy-expert*) and the expertise of Gandhi Nivas; an expertise of a relational ethics of care within a fragmented system response. It was the fragmentation I understood Gandhi Nivas staff were referring to when they told me their *kaupapa is family violence **not** mental health.* But why were so many staff telling me that *"in my job, most of the times [mental health crises are involved], you know?"* (P5). To help increase understanding, the persistence of another figure continues.

The figure of the police officer.

The figure of *the police officer* is the way men are (most often) welcomed into the houses of peace. As police officers are (usually) the first responders to both 'mental health' and 'domestic violence' crises in the community (NZ Police, 2021), staff defer to police's initial assessments of the men when making decisions about accepting a referral into the Gandhi Nivas houses. Though police officers in Aotearoa receive approximately only eight hours of mental health training via an e-learning module at Police College and a refresher once every two years (NZ Police, 2020), they are expected to be able to recognise when the man is an appropriate referral for Gandhi Nivas (i.e., when the crisis is one of 'domestic violence') and

when they should take the man to the *figure of the psy-expert* instead (i.e., when the crisis is one of 'mental health'). When the police decide Gandhi Nivas is an appropriate referral for the man they are working with, they engage in an initial phone discussion with Gandhi Nivas staff to confirm the decision. At this point, staff inquire about the man's recorded history of 'risk' (*mental health **or** domestic violence?*) and his current presentation to determine if Gandhi Nivas are *"the right people"* for him. However, staff acknowledge how difficult it can be for *the police officer* to make this decision during moments of crisis:

> *"Even just after the incident they are either agitated, angry or very vulnerable crying or in an emotional state so not sure [whether it is mental health or domestic violence]. But when they start staying here that's when we can notice, if we have our catch ups and things. Or you know, seeing him, how he behaves in the house, yeah, then we sort of get to know. But not at the initial intake time"* – P5

Here participant five navigates the boundaries of expertise between the manifestations of psychological distress that are within Gandhi Nivas staff's supportive capacity and the manifestation of a 'mental health crisis' that is understood to be the territory of *the psy-expert*. She acknowledges this is a tricky distinction to make in the initial aftermath of crises and often depends on more sustained engagement and building relationships with the men. As Gandhi Nivas staff share everyday life with the men who are staying in the houses of peace, they can increase the adequacy of their understandings regarding what is 'normal' for a man and what is not, and this situated knowledge increases their abilities to respond ethically. However, through the institutional and social hierarchies of knowledge production (the privileging of *a (masculine, justice-orientated) voice)*, the expertise of these forms of knowledge is eclipsed by the knowledge of *the psy-expert*, knowledge that depends on particular forms of legitimated expertise such as those traversed through my literature review. Thinking with participant five and recognising the eclipse of this expertise helps me understand the difficulties for the *figure of the police officer* when making decisions about appropriate referrals in initial crisis situations where both 'mental health' and 'domestic violence' are present and cannot be separated. I remember from my literature review that police officers are often required to (temporarily) fill in for the figure of *the psy-expert*, being positioned as 'frontline mental health workers' (McLean & Marshall, 2010)

who have to plug the gaps in community care left by an overwhelmed mental health system post-deinstitutionalisation and the escalating demand increasingly visible in the inequities of everyday lives. I remember the feelings of frustration and powerlessness spoken aloud by the police officers who are put in these positions without the resources or support to be able to respond ethically (Gur, 2010; Holman et al., 2018; Marakowitz & Watson, 2015; Marsden et al., 2020; McLean & Marshall, 2010; Ogloff et al., 2020). Indeed, Gandhi Nivas staff do not take decisions to refer to *the psy-expert* lightly or in isolation; however, the figure of *the police officer* is expected to be able to make this decision quickly in the context of crisis events and to get it 'right'.

Sometimes the *figure of the police officer* is helped by the psy-expertise that they have available to them when making a decision at the time of crisis, participant five continues:

> *"Most of the time, the police do have it [mental health history] on file. But sometimes when…the client is not from Auckland or…ages ago he had some mental health concerns and after that he's been doing fine, or um, sometimes the police just miss that out"* – P5

As participant 5 explains, though some information from *the psy-expert* could be available to *the police officer*, this could be complicated by the man's unique circumstances (e.g., whether he was currently in the geographical area in which his health concerns were registered) or by the interpretation of the mental health history on file by the officer in the context of a domestic violence crisis. If there is no information on file for *the police officer* or if the information is dated, the officer defers to their own mental health skills and expertise to make a decision regarding referral. Staff explained to me that it was understandable officers did not always make the right decision, recognising the experiences of officers' everyday policing informed their decision-making through the character of their job and the constraints of their locations produced through the dominant *thoughts that think thoughts* about the crises. But *"sometimes the police just miss that out",* participant five said, and other participants offered similar stories. To make sense of the missing, I reconnect with work done by Holman et al. (2018) that demonstrates that more than half of the people brought in by police for mental health assessment do not meet *the psy-expert's* threshold for response and are returned to the community without further

intervention. I remember April and her emphasis that her partner needed *"help"* and *"support"* and I remember *the psy-expert's* decision that her partner did not meet the threshold for *"compulsory assessment"* and *"treatment"*. From here, I can understand that *the police officer* sometimes *"just miss[ing] that [mental health] out"* is not necessarily an oversight or gap in expertise but could be understood as a careful response to these men by police officers (from the vantage point of *the police officer*). In the context of an overwhelmed and over capacity mental health system (e.g., Patterson et al., 2018), the officers recognise that getting men to *the psy-expert* may not lead to an affirmative response where the men are provided with immediate *"help"* and *"psychological support"*. In South and West Auckland, through their partnership with police, Gandhi Nivas agree to provide (and police agree to refer as appropriate) an alternative response where the men will be met immediately with care and begin a relationship with staff to help engage additional support services. Participant four articulates her understanding of the way police make sense of these situations and how it might feel for police, after explaining a situation where police officers did not disclose known mental health concerns to her:

> *"So taking him from that situation….bringing him here hoping "oh as soon as we put him here he's off our hands, we don't have to arrest him. Half an hour we keep him, if we keep him more we'll have to arrest him. We cannot. What do we do with him? We'll just go put him in Gandhi Nivas"* - P4

Faced with the complexities of engaging with the figure of *the psy-expert*, participant four suggests police see Gandhi Nivas as an alternative referral for the men. Despite not being *"the right people"* for men experiencing *'mental health crises'* in terms of the territories of knowledge on normalcy, Gandhi Nivas staff become *"the right people"* in the direct aftermath of both mental health **and** domestic violence crises when the only other options offered to *the police officer* are criminalisation or returning response-ability for care and safety to families. Gandhi Nivas offers a space where immediate *"help"* and *"psychological support"* can be provided, as April had been searching for on the day I am remembering with her. Coming to the whare begins a relationship for the men and their families with staff; in coming to the whare men and their families become a *'we'* with staff, and together navigate through the fragmented and incoherent system and the precarious conditions of everyday lives to attend to potentia: *"what we are in the process of becoming"* (Braidotti, 2019b, p.37).

There are connections between April, Gandhi Nivas staff and the figure of *the police officer* at this point in my cartography; all move for connection with *the psy-expert* when faced with what is understood through the dominant *knowledges that know knowledges* as a convergence of two crises: mental health and domestic violence. However, as staff explained to me, Gandhi Nivas presents a departure point of sorts for *the police officer*; a space *the police officer* can bring the men and (temporarily) leave, because Gandhi Nivas become *"the right people"* in the moments after a crisis to care for the men and (re)connect them with *the psy-expert* when *the psy-expert* is not immediately accessible. There are significant impacts for Gandhi Nivas staff through this recognition as *"the right people"* by the figure of *the police officer*; impacts that will be explored in a further section of my analysis. However, staff explained to me that if they believe they can safely accept a referral from *the police officer*, they will do anything to ensure they welcome the man into the whare. I understood that although their *kaupapa was family violence not mental health*, staff knew the delineation between the two crises was far from clear and often misunderstood, and if they *could* respond, they *would*, because as participant two said to me: *"well, what options have we given them as a system? Nothing."*

In the face of *"nothing"* (P2), Gandhi Nivas staff who become *"nobody"* (P1) to speak on mental health issues compared to *the psy-expert* become the *"right people"* to respond immediately (within their abilities) to those at the convergence of 'mental health' and 'domestic violence' crises. As I think about this *"nothing"*, I remember conversations from the first day I met (some of) the Gandhi Nivas staff in the offices when they suggested that where the crises meet is a *"black hole"* in terms of service provision and understanding. Having recognised the territories of knowledge that configure the spaces of the Gandhi Nivas houses and leave a *black hole*, and the figures who persist in appearing through the configuration of spaces, I now move towards hearing the stories of Gandhi Nivas staff and recognising the skills they use to respond to those who are brought into their care when the only other option is *"nothing"* (P2).

Where care makes a difference….

As I continue my *"retelling, reconfiguring, and revisiting"* (Braidotti, 2010, p. 412) of April's story with the stories of Gandhi Nivas staff, I notice how at this point in our story it has been challenging for me to hear *a different voice* from Gandhi Nivas. As staff recognised me in the figure of *the psy-expert* and respected the boundaries of expertise around 'mental health crises' in their everyday working lives, the voice of *the psy-expert* dominated. It was not alone, however; I **could** hear *a different voice* too. It was the voice that told me that we had given clients, their families and police officers the option of *"nothing"* from system responses when it came to entwined 'mental health' **and** 'domestic violence' crises, and it was the voice that welcomed every person with a smile and a cup of tea as they walked through the doors of the whare. It was the voice that was sure I heard Gandhi Nivas supported the men **and their families** and the voice that helped me recognise Gandhi Nivas staff *listen to (hear) pain for real.*

April supported her partner, listened to him as he spoke, and when she realised the situation was beyond her supportive capacity, she called the mental health crisis team. The crisis team had informed April that they were stretched to capacity but would be there as soon as possible.

Her partner left, April called the police as she was concerned for his safety, and they were (eventually) brought to the police station [for a mental health assessment].

The mental health team didn't section April's partner that day. They decided that the 'crisis' was a 'domestic violence issue' and not that of mental health.

April had denied the help of the police, as they could only offer her legislative instruments that would criminalise her partner for his actions.

But, now, the police could offer April's partner support and temporary accommodation from Gandhi Nivas; a house of peace. The staff in the house could support her partner, listen to (hear) him as he spoke, and if they realised the situation was beyond their supportive capacity, they could call the mental health crisis team.

What's more is they wanted to listen to (hear) April too, and the staff recognise that helping April care for her partner is providing a safety response; or in other words, caring for her partner and April too is an-other other-wise way to respond to the figure of 'a risk to be managed'.

As we spoke and staff would tell me about *"working with somebody who is struggling with managing their wellbeing"* (P2), I recognised staff's deferral to *a voice* from *the psy-expert* when speaking *about* 'mental health crises'. However, when staff shared stories of *responding* to the crises and interacting with the figure of *the psy-expert,* it became easier for me to hear *a different voice*. This *different voice* privileged care as connection and increased the staff's response-abilities. As part of enhancing their response-abilities, Gandhi Nivas staff extend their focus on relationships beyond the men and their families and into the communities in which each house of peace is located. During my ethnographic experiences in the houses, on occasion I would walk into the shared common areas in the houses to find a spread of delicious looking food and staff conversing with visitors from local community agencies. Staff explained these were *'catch ups'*, or relationship building practices that were necessary to the work staff do to support men and their families; necessary as partnerships through the sector form a community that attempts to *care with* Gandhi Nivas and people like April. Often staff expressed to me a connection point of frustration, shared through their partnerships, that fuelled the creation of alternative responses. The expression of connected frustration was often done through an acknowledgement of being part of *'the system'*.

'The system' was a phrase that was used often around the houses of peace. I recognised the phrase as signifying the assemblages of different disciplines and agencies one has to traverse to be able to receive mental health, social or safety support from government funded services. *"We get a lot [from clients] of 'system is bad', 'system makes you go around in circles'"* participant three explained to me. As staff and clients alike used the phrase *'the system'* differently similarly, I noticed an affective acknowledgement of the harm done through a system that responsibilises the individual through compounding requirements for 'assistance' and recognises difference only through *'a risk to be managed';* in other words, I recognised *'the system'* privileges an ethics of justice or the separation of self from relationships. As Gilligan (1995) explains, the separation of self from relationships also relies on *"the separation of the public world from the private world"* where the public world is *"a realm of human activity which can only be maintained as long as someone cares about relationships, takes care of the private world and feels bound to other people"* (p.122). Remembering my day my April, that *'someone'* who would take care of her (and her partner's) private world was her; everyone else she came across when

asking for *"help"* and *"support"* instead located themselves in the *public world*. This included myself, as the police officers, psy-experts and I did not act on response-abilities beyond our job descriptions and territorialised boundaries of expertise. At Gandhi Nivas however, I noticed there was a smaller separation between the *public world* (staff as social workers, counsellors, in-house coordinators) and the *private world* (staff as *"someone who cares about relationships, takes care of the private world and feels bound to other people"* (Gilligan, 1995, p.122)). Through *caring about relationships and feeling bound to other people*, Gandhi Nivas staff recognise that building partnerships with community service agencies, leaders, locals, cultural and religious assemblages and other non-government organisations attempts to connect fragmented parts of the assemblage of *'the system'* and can increase their response-abilities to the men and their families.

Participant one articulates the way he understands the attempts to connect fragmented parts of *'the system'* in his work at Gandhi Nivas, after telling me about the *'catch ups'* with people who work in community agencies and how they have resulted in good and helpful experiences in his everyday working life.

> *"We work like a bridge. We are a bridge between the client and the organisation – the agencies."* – P1

Acting as *"a bridge between the client and the organisation"* (P1) is an important part of responding to men who are "*struggling with managing their wellbeing*" (P2) as it enables staff to try and engage community care responses for the men before the men's situation escalates to a crisis which needs (and may justify) intervention from *the psy-expert*. Staff would tell me how often men would come in who *had* been engaged in community care services for their mental wellbeing concerns (e.g., with a key worker, support staff, nurses) but the men were often no longer in a sustained relationship with the support staff (for various reasons). As staff would continue to *listen to (hear) men's pain for real*, men would share the various support services they had tried and how they felt about them. When staff recognised there was potential to (re)connect men with prior community support staff, they would do so, and this would be much easier if the support staff knew who Gandhi Nivas staff were and what they did. I recognised the (re)connections with community care as vital when working with men who have been labelled a 'perpetrator' of domestic violence and/or 'mentally unwell', remembering the literature that

amplifies the voices of services users and their preference for community-based care solutions (e.g., Boscarato et al., 2014; Patterson et al., 2018; Roguski & Gregory, 2014). Through the partnerships between Gandhi Nivas and other community-based services, the movement of the figuration of *'a risk to be managed'* is supported through a continued focus on the men's potentia and an attempt to reduce the fragmentation of his (*and his family's*) experiences. I recognise these working affirmative partnerships calling for the recognition of the multiplicity of difference through *different voices; different* from the framework of justice that is privileged in '*the system',* instead privileging care as connection and the recognition of humans as *"responsive, relational beings"* (Gilligan, 2014, p.90).

Sometimes the men's needs for support however went beyond the capacity of community-care based solutions as staff recognised that a man may pose *"a serious danger to the health or safety of that person or of others"* (Mental Health (Compulsory Assessment and Treatment) Act, 1992). As on my day with April, guided by *'the system'* and the (culturally specific) *psy-expertise* that is privileged in system responses, Gandhi Nivas staff knew that in these situations their response-abilities and careful attention to their boundaries of expertise required them to engage the figure of *the psy-expert* (as April had tried to do too). However, staff would make these decisions (as much as possible) *with* the men they were working with; gaining their consent to engage *the psy-expert* was vital. *"You cannot force support onto a client, we have to be mindful of that"*, participant three told me. Not forcing support was part of *listening to (hear) pain for real* and enabled the *"cultivation of affirmative relations"* (Braidotti, 2010, p.413) between staff and the men, which were then enabled to flow with the men (***and their families)*** as they moved in and out of the whare and through the community partnerships where possibilities for recognition of the multiplicity of difference could materialise.

(Re)connecting a fracture in a flow of care…

Participant two shared with me a story about engaging with figure of *the psy-expert* when working with a man who was *"struggling with managing his well-being"*. She told me about a man who had been welcomed into the whare on multiple occasions; he had had tremendously difficult experiences with *'the system'* and staff had found it challenging to keep his engagement with them sustained. On one particular day, the man showed up the whare without an appointment to find

participant two because he needed *"help"* and *"support"* and he knew that he might find that in the house of peace. As participant two sat with the man over a cup of tea and *listened to (hear) his pain for real*, he shared with her that he was planning to end his life and had the means to do so. Formalising her concerns through a Kessler risk assessment and discussions with her team members (as staff respect and attend to the hierarchy of institutional and social knowledge production and therefore make decisions regarding 'mental health' carefully), participant two asked the man's consent to be a *bridge* between him and the figure of *the psy-expert*. After some discussion the man agreed; participant two and a fellow staff member brought the man to the mental health assessment team at the nearest hospital.

As participant two continued her story, I noticed how a flow of care and connection was in process to get the man to the hospital. The relationships built between the man and the Gandhi Nivas staff had brought him back to the house of peace in his moment of crisis to seek *"help"* and *"support"*. The relationships between the Gandhi Nivas staff members had facilitated the decision to bring the man to the hospital to meet *the psy-expert*. However, on arrival at the hospital, the flow of care was disrupted by a booming dominant voice; the same voice I have noticed dominating throughout my cartography – the (masculine) voice of *the psy-expert* or an ethics of justice (the separation of self from relationships). Participant two explains the psychiatric nurse who met them at the hospital had recognised the man as the figure of *'a risk to be managed'* and had focused strongly on a *'risk'* he presented (the repetition of the psy-disciplines' relationships to the *totalising madness* of a Society-of-Captives). However, it was not the same *'risk'* that participant two was attending to when she brought him to *the psy-expert*. While participant two was concerned with the man's plans to take his life, she explains that the psychiatric nurse focused instead on the possible *'risk'* the man might be to her. Or in other words, the nurse had separated her-self from relationship with the man. She had sat down with the man (and participant two) and started reading questions off the risk assessment form in front of her, participant two explains:

> *"That nurse was rude, disrespectful…[she asked] "how do you want to kill yourself?!"…So, "did you try killing yourself?" and he just got triggered, triggered, triggered. And he said you know, "she's making me angry!", and she just kept asking him those questions. She panicked! She pushed the buzzer and she ran. Out of the room"* – P2

Here I notice the difference between *"a conversation that fills in paperwork"* and *"paperwork that fills in a conversation"*. Participant two had conducted a similar 'risk assessment' to the one the psychiatric nurse had in front of her prior to arrival at the hospital, but it had been a conversation over a cup of tea, rather than facilitated by the risk assessment form. The conversation had encouraged connection and trust between the man and participant two, whereas the paperwork-led risk assessment at the hospital had facilitated a disruption in the flow of care. I return here to participant two's words from earlier, where she told me that if you *"feed into that fear"* felt by *"someone who is struggling with managing their wellbeing"* it means *"you've lost the person"*. However, participant two recognised that the fault or disruption in the flow of care did not lie with the individual nurse:

> P2: *"....and it's not her. It's the system. You know, she was rude, there's no doubt, but she was just doing her job."*
>
> H: *"She's just following what she's…*
>
> P2: *"...what she needs to. Um, I know it, as a professional, that she's following her job. But that triggered because that's what the system does to you. "How are you going to kill yourself?!?!". I mean, I can think of a hundred ways to rephrase that. Yeah that paper says "how is the client going to kill themselves". That's not how you ask! Then you get answers like [that]".*

Participant two locates response-ability for the fracture in the caring relationship with 'the system', which I recognise now as *a (masculine) voice* of an ethics of justice; the separation of self from relationships (Gilligan, 1995). She explains to me that the nurse was *"just doing her job"*, the same way that I was *just doing my job* on my day with April when I watched her walked out of the police station without support or safety services. But participant two reconciles the split of the public world where people are *just doing jobs,* with the private world where *someone* feels *"bound to other people"* (Gilligan, 1995, p.122). She felt bound to this man, response-able to this man, and so although the nurse ran out of the room in fear, participant two stayed sitting right next to him and they began to share stories. She told me about how she noticed the man was shaking, breathing heavily and rubbing his arm very quickly. Under his rubbing hand, she noticed a ta moko on his arm and asked him to tell her about the meaning behind it. The man started to share

the story of his ta moko and the taniwha it depicted. As participant 2 *listened to (hear)* his story about the taniwha and his iwi[13], she noticed his breathing slow down and the shaking stopped. When he had finished his story, she thanked the man for sharing and offered her own story in response. She had noticed a connection between the taniwha and the iwi the man spoke about and a story that had been shared with her by her Māori professional supervisor that also included taniwha and the same iwi. Speaking aloud this connection repaired the fracture in the flow of care and allowed an ethics of care to lead the interaction again, the same way it had in the house of peace prior before arrival at the hospital. As the fracture in the caring relationship began to heal, participant two tried again to connect the man and the *psy-expert*:

> *"And then I said, "okay, now we do need to answer those questions, would it be okay if I found somebody else from the team, cause we are here for help and we need that help. You know, you've put all of this courage together to get that help…can I go and bring somebody?". And then he said "yes"* – P2

By focusing on caring connection *("**we** need that help",* not "you"), participant two was able to bring in another *psy-expert* to speak with the man. Prior to the second *psy-expert* meeting with the man, participant two explained to the *psy-expert* what had just happened and offered suggestions for how it may be useful to approach engagement with the man. By advocating for her client and privileging *a different voice*, a relational ethics of care, participant two enabled a safe and consented to admittance to the mental health ward for the man. She explained she did not meet the man in person again, but continued a relationship with him over phone, as he continued to connect with her throughout his journey. As she shared her story with me, she told me that the last time she had heard from this man he had been graduating from a residential alcohol and drugs programme and was many months sober. A tear rolled down my cheek as she finished her story and I thought about what she had enabled not only for the man, but also his partner and children at home, and those he shared wider connections with through his whānau and community.

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[13] I pause here to acknowledge the use of local indigenous concepts 'ta moko', 'taniwha' and 'iwi'. In taking up an offering to becoming tangata Tiriti, I will not claim to 'know' what these terms mean or to suggest that I can provide an adequate 'translation' (as translations are always critical, partial and interpretive, Haraway (1988) reminds). Instead, I encourage a reader unfamiliar with these words to engage their own processes of becoming response-able through relationships with tangata whenua; I offer suggestions of writers such as Linda Tuhiwai Smith and Ani Mikaere to learn to *think with*.

Here was a different telling of April's story, enabled by Gandhi Nivas staff leading with *a different voice* through *a relational ethics of care* that acknowledged the potentia and interconnectedness of life (Braidotti, 2019a; Gilligan, 2014; Mikaere, 2011). Here was a (re)telling of April's story that enabled a recognition of the *felt missing* of experiences that cannot be seen or heard through *a voice* of psy-expertise that privileges (culturally specific) sameness and responsibilizes an individual for social and structural problems.

A disconnect in the flow of care and what happens in the 'black hole'....

Participant two's story above was just one of many shared with me where the care and advocacy of Gandhi Nivas staff enabled the *figure of the psy-expert* to continue the caring relationship. However, staff also shared stories with me where despite their best attempts to engage *the psy-expert*, *the psy-expert* decided the man did not meet the threshold for an immediate psy-expert response (as they had on the day I am remembering with April). However, *"we are not leaving our clients so easily"*, participant one taught me. Participant five shared a story about response-ability for *"help"* and *"support"* being returned to Gandhi Nivas staff; the *black hole* we had discussed on my first meeting with staff. She was working with a client who was staying in the house and had a mental illness diagnosis on file. One night she explained he kept coming to see her to tell her he could not sleep because he had not picked up his prescription sleep medication from the pharmacy and instead was pacing up and down the halls of the house. He explained to her he could hear noises that she could not hear and that he knew it would go away if he could access his medication. Listening to (hear) the man and understanding his needs, participant five rang the mental health crisis team to investigate how to get the man access to his medication now that the pharmacy was shut for the day.

> *"So I called the crisis team...and I said "can you please"...[and the nurse said] "oh you don't even have to give it to him, he should have just collected his prescription"....So I asked "can we bring him there so that you can give him you know, the medication, give him one medication or can I call the ambulance?"...and she said rude things [to him like] "oh instead of doing all these things you should have just sat there for some more time and collected your medication"...and that's it."* – P5

Though participant five had recognised the need the man had for medication and had responded by trying to connect him to *the psy-expert* to avoid a more serious 'mental health crisis', the *psy-expert* had decided he did not meet the threshold for an immediate response and had returned the response-ability for *"help"* and *"support"* to participant five. The *psy-expert* had not *listened to (hear) pain for real* and had instead emphasised the personal irresponsibility of this man. With a fracture in the flow of caring relationships, participant five was left in the house with a man who was *"struggling with managing his wellbeing"* (P2) and unable to sleep. In the absence of the figure of *the psy-expert*, she and her colleague had filled the *black hole* with caring relationship practices. The man asked to stay in the office with participant five rather than returning to his room, and participant five heard his request for connection and relationship. *"Yeah yeah definitely yes, you can sit here"* she had responded. The man lay down on the couch in the office and tried to go to sleep while participant five continued her work.

> *"And then my colleague came in and then he [client] asked him [colleague] it seems "can you just pray for me? I need to sleep". So my colleague said "okay, I'll pray for you". So he took him to the room and he just prayed and then he slept. And the next day morning he said "you know what, he came, you know your colleague, he came and then he prayed for me. I slept like a baby", he said".* - P5

In the absence of the provision of sleep medication or a continuation of a caring relationship from *the psy-expert*, Gandhi Nivas staff had responded by listening to (hear) the man's needs (and *pain for real)* and by praying with and for him to sleep. I recognised (with Gandhi Nivas staff) that praying with and for the man to sleep was an act of care in his every day, and that it took time and energy that surpasses the provision of a medication prescription; participant five and her colleague felt response-able to the man, *"bound to other people"* through an ethics of care (Gilligan, 1995, p.122). As she recalled her story to me, I realised the difference made when *a different voice* (different from the (culturally specific) expertise of *the psy-expert*, different from *a (masculine) voice* of an ethics of justice that separates the self and relationships) leads interactions and responses. I understood this *different voice* as the *"help"* and *"support"* April had been looking for to help her partner and enhance her response-abilities and exhaled with relief as I realised someone could hear *her (different) voice* and was able to respond.

As staff continued to share their stories with me about engaging the figure of *the psy-expert*, I noticed that often *a different voice* (of Gandhi Nivas staff, April and an ethics of care) remained unheard by *the psy-expert*, as it was in participant five's story above, or when it was listened to, it was eclipsed by *a (dominant) voice* of (culturally specific) psy-expertise and a justice framework. I noticed that I had read about the eclipsing (of *a different voice)* before, in Carol Gilligan's (1986; 1995; 2014) follow-ups to her offering of *A Different Voice* to the field of psychology in 1977. As noted earlier, Gilligan's *different voice* had been relegated to the realm of women and had been acknowledged as a *feminine* voice, rather than a *feminist* voice. *Feminine*, Gilligan and Snider (2014) explain, because of the patriarchal social structure that encodes life as we know it; *"'feminine' because in the gender codes of patriarchy, relationships and emotions are women's preoccupations"* (p.107). In relegating relationships and emotions as *women's preoccupations,* the gender codes of patriarchy (re)produce a binary where women are understood to be what men are not, and therefore *a different voice* offered by Gilligan (1977) is recognised as feminine against *a* (dominant) *voice* of rationality, objectivity and a hyperintensive focus on an individual that is heard as a *masculine* voice. In *'the system'* that privileges a dominating (culturally specific) voice of justice and *the psy-expert*, understood now (also) as a *masculine* voice, relationships and emotions are suggested to taint the rationality and objectivity and therefore become recognised as less than expertise. Here I notice the reproduction of Kolhberg's (1977) moral framework, where a bounded individual is premised as the pinnacle of moral achievement, and a focus on relationships and emotions is seen as a step on the way up the moral hierarchy (and therefore lesser than 'achievement'), as well as the continued separation of worlds public and private.

But Carol Gilligan (1995) emphasises that her offering of *a voice* was not a *feminine* voice, but a *feminist voice* of resistance; *a-different-voice-that-was-(also)-the-voice-of-(some)-women.* Here I think with Braidotti (2010) as I understand that through a patriarchal gender binary, all voices that *differ* from the exclusionary category of the 'human' (i.e., the figure of a subject that is white, masculine, heterosexual, urban, property-owning and speaking a standard language) are coded through the binary as 'feminine', as *lesser-than-expertise*. As the binary homogenises difference through a single 'feminine' category, the hierarchical dominance of a patriarchal social structure refuses to acknowledge the necessity of

both justice **and** care in interrelational living and dying and constrains ways of doing humanness (Arrigo, 2013). Despite a refused acknowledgement from figures of expertise, the necessity of care, the multiplicity of difference and the interrelational character of life continues, resisting the reproduction of the homogenised binary. However, without a recognition of care as expertise, the (apparent) separation of the *'public'* and *'private'* world continues and care is relegated to the *'private world'*, attended to (most often) by those excluded from the category 'human' as they become the *"someone"* who maintains the human activity of the *'public world';* in other words, the *"support"* and *"help"* April was searching for assistance with (and that was a recognised need in the Gandhi Nivas whare) is understood through relational care practices as a requirement of the interdependent character of living and dying together, but remain missing from the dominant understandings and knowledges of the crises through the flows of social power relationships within a context of advanced cognitive capitalism (Braidotti, 2019a).

I am (re)joined by Mikaere (1999; 2011) here who reminds me that care work is not shared equally by all those excluded from the category of 'human', as social power relationships involving race, colonisation, class and imperialism (and, and, and) are entwined with the patriarchal social structure too, and it is notable that in Aotearoa, Māori and Pacific racialised and feminised bodies do the majority of the (recognised) care work (Ministry of Health, 2021b). Recognising the complexities of these social power relationships, Gilligan and Snider (2014) suggest the complexities are still (only) understood through patriarchy's binary system: *either* masculine (and therefore 'human') *or* feminine (and therefore 'other', and less than). All those coded as *different from* a masculine-human voice in a patriarchal social structure are hierarchically organised as *lesser-than-expertise* or un-able to contribute to the adequacy of understandings. In this misrecognition and miscoding of necessary relational care practices, the *"black hole"* recognised by Gandhi Nivas staff on the first day I met them is continually reproduced and the figuration of a *'risk to be managed'* through a hyperintensive focus on individuals tenaciously persists.

I understood April's voice had been listened to as *feminine*, as less-than-expertise rather than *heard* as a different vantage point to *think with* to increase the adequacy of understandings. In this detection of the sounds 'the system' wanted to hear (Waitere & Johnson, 2009) an assumption had been made that April would *take care* of her partner in the absence of response from the public world and that it was

her personal response-ability to do so, with no attention to the interrelational character of life (Mikaere, 2011) or the threshold of sustainability of what bodies can do (Braidotti, 2006b). Now I realised that often Gandhi Nivas staff were listened to through this frame that recognised them as *lesser-than-expertise* too, a misrecognition produced through the *totalising madness* of the figuration of *'a risk to be managed'* within a patriarchal social structure that emphasises *"the god trick"* (Haraway, 1988) and therefore the inadequacy of understandings. As I moved from *listening* to *hearing* Gandhi Nivas by working with, speaking with and thinking with them in the *"black hole"* left by 'the system' at the convergence of 'mental health' **and** 'domestic violence' crises, I became able to hear *a different voice* as other-wise, not as a *'feminine'* and *lesser-than-expertise* voice. By beginning with a recognition of the multiplicity of difference, I heard an(other) expert voice, *a different expert voice* that responded to men not with objectivity and rationality, but with care and a focus on emotions and relationships. *A different expert voice* that enabled other-wise tellings of April's story and becoming response-able as a 'we', as an experience of joy.

Hearing the voice of a relational ethics of care as *a different (expert) voice* in the houses of peace enabled me to hear Gilligan's differentiation between a *feminine* and *feminist* voice. Gilligan and Snider (2014) suggest *a different feminist voice* can be heard as a *human* voice when not encoded by a patriarchal hierarchy that privileges the separation of self and relationships. Hearing *a different voice* as a *human* voice enables Gilligan (1995) to hear it (also) as a voice of resistance to the fractures in connection that are legitimated through the patriarchal binary and an ethics of justice (the separation of self from relationships). It is the voice that reminds us we are *"responsive, relational beings, born with a voice and a desire to live in relationships"* (Gilligan, 2014, p.90). What Gandhi Nivas staff needed, I realised, what April had needed and what I had needed, was for the voice of an ethics of care to be heard by 'the system' as *a different voice* (of expertise), a *feminist* voice of resistance, rather than as a lesser-than, *feminine* voice, recognising the multiplicity of difference and releasing performances of the *god trick* (Haraway, 1988). Here, *listening to (hear) pain for real,* recognising doing humanness differently outside of the constraints of a 'risk' paradigm and acknowledging the structural and social conditions of everyday lives as a key site for intervention enable response-able

responses to those at the entwined crises of 'mental health' and 'domestic violence',
constituting vital forms of *different* expertise as situated knowledges.

Hearing, speaking with and thinking with differently knowing voices…

As I heard *a different voice* (through a relational ethics of care), a voice beginning *"with connection theorised as primary and seen as fundamental in human life"* (Gilligan, 1995, p.122), I noticed the multiple connection points of similarity and difference in April and Gandhi Nivas staff's stories traced thus far. Particularly, I noted how both April and Gandhi Nivas staff had often been heard by *the psy-expert* only as a *feminine* voice, a voice *lesser-than expertise,* reproducing the patriarchal binary. Heard as a *feminine* voice by *the psy-expert* who privileges rationality and objectivity (i.e., a *masculine* voice) over relationships and emotions, it becomes permissible for the figure of *the psy-expert* to return the response-ability for *"help"* and *"support"* to April, to Gandhi Nivas staff. Permissible because *"help"* and *"support"* involve emotions and relationships, seen as part of the private world that is sustained only through care by *someone* (Gilligan, 1995) – nameless through the intangible felt missing and misrecognition of expertise. Through a patriarchal structure or justice framework where a *feminist* voice is heard as *feminine,* *"selflessness or self-sacrifice is built into the very definition of care"* (Gilligan, 1995, p.122). Pausing on the notion of *self-sacrifice*, I remembered the blood and bruises on April's body and the stories she shared with me about traversing *'the system'* to find support for her own experiences of mental distress: was this the kind of self-sacrifice built into the definition of care in a patriarchal order that Gilligan was referring to? Unfortunately, stories of physical violence and mental distress shared with me by April were also shared with me by the Gandhi Nivas staff as they told me stories about performing care work in a patriarchal social structure (i.e., where *"self-sacrifice is built into the very definition of care"* (Gilligan, 1995, p.122) through a reproduction of the patriarchal binary and an ignorance of the multiplicity of difference (Braidotti, 2019a)).

An ethical pause…

Gandhi Nivas is a small community-based organisation where staff know each other closely. The five participants I spoke with formally brought voice to stories of experiencing physical violence and mental distress when responding to men they understood to be experiencing **both** a 'mental health' **and** a 'domestic violence' crisis. The staff I spoke with informally as I was 'hanging out' in the

houses of peace shared similar stories with me. The staff also share these stories with each other, meaning that features of the stories are well known by staff throughout the three whare. In this setting, I recognise that bringing specific stories of violence and distress onto the page and quoting participants directly risks the confidentiality of this research project. To minimise the risk of identification for my participants, I write to the general features of these stories in my own words, rather than specific details in the participants' words.

Experiences of "too much!"[14]

Many staff told me stories about men becoming suicidal and planning to take their life while in the houses of peace. In these situations, staff would try to engage the figure of *the psy-expert* (as I have shown in earlier stories). When there was not an immediate response from *the psy-expert*, or when the men had been 'cleared' by the figure in terms of 'mental health', the response-ability for the men's safety stayed with Gandhi Nivas. Staff told me that from their perspective this meant they were on active suicide watch to care for the man and would spend time constantly checking on his wellbeing while he was staying in the house of peace (and more intermittently so when he left). On most of my visits to the houses, there was a single staff member on duty (the houses are funded for one staff member per house, per shift) and between 2-8 men staying in the whare. The single staff member would spend their shift supporting all the men staying in the house, as well as doing home visits, accepting new referrals from police, doing counselling sessions and social support for families and for men who were no longer residing in the temporary accommodation. I was impressed by what each staff member managed to do as a *single staff member* on a shift. I could not fathom how they could manage an active suicide watch on top of their everyday working lives. As I articulated this response to staff, they agreed that it was very challenging work and caused them a great deal of stress; they felt response-able for the man staying alive while he was in their care, but they also felt response-able to all other clients and the families they were supporting. Staff told me that in a *"perfect world"* and with a *"magic wand"* it would make a huge difference to their working lives and their experiences of stress if they were funded for more staff members on a shift at a time. However, even then,

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[14] Braidotti (2006b, p.239)

they told me, these were men who needed support that was beyond the *kaupapa of Gandhi Nivas as 'family violence'* **not** *'mental health'*. In the absence of the recognition of multiple differences and an increase in the adequacy of understandings through such a recognition, staff and I were left with the persistence of the *"black hole"* produced at the convergence of the two crises.

There were other men too, staff explained, who were brought into or returned to their care and who needed support that was beyond the *kaupapa of Gandhi Nivas*. These were men who posed a safety risk to staff, other men and/or the whare, and staff shared stories with me of being threatened with weapons, intimidated, being trapped by men in rooms, destruction of property and verbal assault. Staff did not share these stories with me as 'victims', I noticed, in the same way that April had refused to be categorised as a 'victim' on my day with her. Instead, they told me these stories to demonstrate the extent that a man needed support that Gandhi Nivas could not provide alone. I recognised these stories as similar to the calls of *"too much!"* (Braidotti, 2006b, p.239) that staff were skilled at hearing from men and their families; the complex intensity of these experiences signalled a need for connection with an-other to enable safety provision, but the *"black hole"* appears more visibly in these spaces through inadequate, partial understandings traced through my literature review. In the absence of connection to an-other to continue the flows of care and connection, staff were more than willing to still support the men and their families, they would tell me, but once a man had posed a safety risk to staff or anyone else in the whare, he could no longer take up accommodation in the house of peace.

As staff shared these stories with me and reminded me that these kinds of experiences were why the *kaupapa of Gandhi Nivas is family violence not mental health*, I recognised these reminders as enabling me to hear *a different voice* as a *feminist* voice of resistance, not a *feminine* voice of self-sacrifice. Staff drew boundaries around the provision of their services when a man posed a safety risk to themselves, staff or others in the houses of peace. In doing so, they reframed *'the system'* in terms of connection and worked to sustain flows of caring relationship practices with the figure of *'the psy-expert'*. When the connection was fractured, staff would work to repair it and offer to share response-abilities when doing so. However, often *'the psy-expert'* heard only a *feminine* voice of self-sacrifice and therefore permitted the return of response-abilities to Gandhi Nivas staff and

legitimated the self-sacrifice as part of *"care"* work. When staff accept response-abilities and men threaten the safety of staff or the house of peace, staff are left with only one figure to (re)connect with.

The (re)emergence of the figure of the police officer

> *"One of my clients become[s] aggressive, I call the police. That's the only option for us"* – P1

As participant one explains, in a situation where a client is being aggressive, even if staff recognise the aggression as a symptom of a mental illness, the only option they have is to call the police. Many staff explained to me that calling the police is an absolute last resort and done only when safety is an imminent concern as they are aware many of the men they work with have had negative experiences with police officers or the justice system; staff recognise the (re)emergence of the figure of *the police officer* may contribute to a(nother) fracture in the flows of caring relationship practices. I remembered April's resistance to engage with *the police officer* on my day with her because of the authority and punishment this figure represented for her. However, Gandhi Nivas staff spoke highly of the work of officers and located the problem again with *'the system'* (understood through a framework of justice privileging *a masculine voice* of *the psy-expert*). Remembering participant two's question (and answer) to me; *"well what options have we given them as a system? Nothing"*, I asked staff what their understandings were of what happened after a man posed a safety risk in the house and the figure of *the police officer* was called. As staff answered me, I heard that most often the police officers would hold the man during his moments of intensity and then drop him off at a friend's or family member's, at a different address to the one where his PSO was served, if it was still active. If the PSO was no longer active, I heard that often police officers would return men to their family homes. Sometimes these stories included the attempt of officers to get a DAO assessment. However, staff explained that often when the police officers responded to calls to the Gandhi Nivas house because a man was posing a safety risk, the man's demeanour would change as soon as the police officer arrived:

> *"These men…when they see the police around or when they see someone who can actually do something, they'll become the most…normal men. They'll say*

all the right things that you want to hear…and so that means I was lying?" –
P4

In the presence of *the police officer*, men's aggressive behaviour would often
cease and, as participant four explains they *"say all the right things that you want to
hear"*. In these situations, the police officers would see no reason to take the man for
a DAO assessment, staff would tell me. Here I recognise what staff were suggesting:
that the figure of *the police officer* represented not just the criminal justice system for
these men, but also a *justice framework*; framed in relational terms through *a
different voice, "justice speaks to the disconnections which are at the root of
violence, violation and oppression, or the unjust use of equal power"* (Gilligan,
1995, p.125). Rather than a *fracture* in flows of caring relationship practices, the
figure of the *police officer* represents *disconnections*, and it is these disconnections
that I hear when participant four talks about *"someone who can actually do
something"*, where *doing something* acknowledges a disconnection in relationship.
Though staff spoke about highly dedicated and caring police officers (and I
remembered the officer and the care and determination in his eyes on my day with
April), it was (most often) the options available to these officers from *'the system'*
that resulted in these disconnections. Once a man has been discharged and 'red-
flagged' from Gandhi Nivas for posing a safety risk *and* has been cleared by the
figure of *the psy-expert*, the only options available for an immediate crisis response
remain the only options left on my day with April: criminalisation and punishment of
a man's behaviour through legislative instruments, or returning the response-ability
for care, support and safety to the man's family: to April.

As participant four asked *"and so that means I was lying?"*, I remembered
the despair on April's face on the day I shared with her; April was adamant her
partner needed an immediate crisis response from *the psy-expert* but *the psy-expert*
was adamant the problem lay instead with the relationship between April and her
partner. April spent her everyday life with her partner and knew what was 'normal'
for him and what was not, in the same way that Gandhi Nivas staff spend a lot of
close and connected time with the men they work with, particularly when they are
staying in the houses of peace. Comparatively, staff would explain that the figures of
the psy-expert and *the police officer* were usually only momentarily around a man:

"We stay with him eight hours in our shift and we know what his demeanour is, but if…the police is spending twenty minutes with him, cracking jokes, talking about food…how are you able to assess him and be like "oh he's cool, he'll be okay. Okay man you stay safe. Okay we'll put you here, we are off". Yeah. Sometimes we feel like we're not taken seriously" – P4

I recognised *not being taken seriously* as Gandhi Nivas being heard as a *feminine* (self-sacrificial) voice rather than a *feminist* voice of resistance; the (repeated) performance of the *"god trick"* (Haraway, 1988, p.581) by a system-response that privileges *a (masculine) voice* of *the psy-expert*, resulting in inadequate understandings and the eclipsing of different vantage points to *think with*. Specifically located in the local community context, the situated knowledge of Gandhi Nivas staff is spoken over through a framework of *justice* and *disconnections* that privileges an **either/or** through the hierarchical knotted social power relationships of imperialism, colonialism, neoliberalism and patriarchy. I think with Braidotti (2019a, p.103) to recognise the importance of moving from an **either/or** assumption and towards *"a matter of and…and…"* to enable a recognition of the multiplicity of difference and the interdependency of life. Without *'and…and'* and the recognition of the multiplicity of difference, situated knowledge outside of the partial and limited frame of psy-expertise is continually delegitimated or ignored and those who fall outside of the exclusionary category of the 'human' are taught *"not to know what [they] know, not to think what [they] think, not to feel what [they] feel"* (Gilligan, 1995, p.123). Perhaps this was why staff privileged a dominant (masculine) voice of *psy-expertise* initially in our conversations about 'mental health crises', I wondered, because they have been told too often that they cannot see what they can see, know what they know, think what they think or feel what they feel.

On one occasion when I asked the question to a staff member about what happened to the men staff have to call the police on, she responded by telling me that the man I had just been sitting in the lounge talking to for more than an hour was such a man. I looked at her with confusion as she recounted the story of having to call the police on him when he had become aggressive, and she told me about how scared she had been. When I asked her *"how come he's allowed back in the house"* she explained to me that men are always welcome to come back to Gandhi Nivas for support. If they have been 'red-flagged' they are no longer allowed to stay in the accommodation, but staff will continue to provide support for the man and his family

as long as they would like it. She explained to me: *"We don't call it a service Hazel, we call it a home. That's why we don't say to people 'come back if you need services again'. We say you are coming home, and you are always welcome"*. Staff continue to focus on the men's potentia (*what they are in the process of becoming*) and recognise the continual processes of becoming other-wise through an acknowledgement of the interdependent and interrelational character of life (Braidotti, 2019a).

As I thought about April walking out the door of the police station that day and how I was not able to get in contact with her again, I wondered where her *'home'* was to *come back to* where she was *always welcome*. It was here I realised how Gandhi Nivas *retold, reconfigured and revisited* (Braidotti, 2010) April's story; though there was still no alternative option for men who were experiencing *both* a 'mental health' *and* 'domestic violence' crisis and posing a safety risk to people around them, there was someone to share the response-abilities for *"care"*, *"help"*, *"support"* and *"safety"* **with April.** There were people that could *hear* April's voice as a *feminist voice of resistance* signalling a *different voice* of expertise, rather than a *feminine* voice of self-sacrifice, and they were standing with her, speaking too, moving for connections with *'the system'* and asking to be heard.

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CHAPTER FIVE: *A* conclusion…

The driving force for knowledge production is therefore not the quest for disciplinary purity, or the inspirational voice of radical dissent, but rather the modes of relation that these discourses are able and willing to open up to

Braidotti, (2019b, p.44).

Our cartography began with the telling of April's story; she was separated, fragmented, isolated and unheard, searching for *"help"* and *"psychological support"* to become a 'we' at the site of the entwined crises of 'mental health' **and** 'domestic violence'. As we traced the figurations of *'a risk to be managed', 'the psy-expert'* and *'the police officer'* that tenaciously persist at this site, we followed the flows of social power relations flagged by these figurations. Here we recognised a patriarchal social structure coding a multiplicity of *different voices* through a binary of **either** *a masculine bounded individual voice of expertise* **or** *a feminine interconnected voice of self-sacrifice.* As we increased the adequacy of understandings through connection with an-other, we saw that positioning bounded individualism as the only *expertise* restricts other ways of doing humanness as *lesser-than-expertise* and *lesser-than-human.* We recognised the ways in which the technologies and knowledges of the psy-disciplines participate in these restrictions and construct the exclusionary category of the 'human' built on social power relationships of speciesism, sexism, racism, ableism and more. *Thinking with* Gandhi Nivas staff, we heard the importance of *caring expertise*, but also of the subordination of this expertise through the permissable violence of the patriarchal hierarchical binary knotted with processes of colonisation, imperialism and advanced cognitive capitalism. *Thinking with* Braidotti (2019a), we began an experience of joy as she offered a move away from an *either/or* and towards **'and...and'** to enable recognition of the multiplicity of difference. Through a retelling of April's story *with* Gandhi Nivas we attended (also) to potentia - *what we are in the process of becoming* – and heard the *difference* care makes.

We end our cartography on the edge of the *'black hole';* the *'black hole'* of the entwined crises of 'mental health' and 'domestic violence', the *'black hole'* where Gilligan's *'private world'* and Gandhi Nivas' *caring expertise* is

unacknowledged, the *'black hole'* of the un-known. The *'black hole'* remains un-known by those who have the powers of discursive representation, such as the figure of *the psy-expert* who continues to perform *"interpretive, critical and partial"* translations as an all-seeing, all-knowing *god trick* (Haraway, 1988, p.589) that disconnects, fractures and separates. To become able to ethically respond to calls like April's for *"help"* and *"support"* needs an acknowledgement of the limitations of any vantage point and the partiality of perspectives for thinking to become a relational activity (Braidotti, 2019a). Becoming response-able is about moving to *think with* an-other to acknowledge multiple forms of expertise in responding to the entwined crises; it is about learning to see the *'black hole'* and *think with* the un-known.

To the staff at Gandhi Nivas,

Namaste.

"Thank you" feels the most obvious, necessary phrase to say to you. *Thank you* for your caring expertise that recognises the potential of each life that interacts with yours and for caring with, through and about a system that continues to insist on the inadequacy of your movement and knowledge. *Thank you* for hearing the calls of *"too much"* (from your clients, community and partnerships) that request connections and assistance to become other-wise together, and for *feeling the fear* with your clients and community as you move together towards affirmation and healing. Particularly, *thank you* for your willingness to *work with, speak with* and *think with* me to enable transformations within myself to be able to *hear* the *differences* your expertise and care makes, and to consider how 'we' might become more response-able, together, to the entwined crises of 'mental health' and 'domestic violence'.

In saying *"thank you"* though, I am *staying with the trouble* of enabling a hearing for you within a system that insists on fragmenting support and marginalising the necessity of care work. I am *staying with the trouble* of the partiality of translations, remembering meetings we shared with government officials where I witnessed you carefully translate the expertise of your care work into their categories and checklists that can be funded, enabling *possibilities* for your communities **and** increasing *response-abilities*. As translations are partial and categories do not enable a *hearing* for your caring expertise, I stand with you to draw attention to the *"black hole"* that is configured through the partiality, particularly when it comes to the convergence of the crises of 'mental health' and 'domestic violence'. I recognise the necessity of your expertise being acknowledged if **we** are to transform that *"black hole"* into more collaborative community partnerships with people who *listen to (hear) pain for real* and become other-wise together.

Thank you for caring for safety through multiple different responses and strategies; for your bravery of working in the *"black hole"* configured by the system and your capacity to endure and repair fractures and disconnections in the flows of care. *Thank you* for your attention to the precarious conditions of everyday lives and the patriarchal social structures that underpins manifestations of harm and violence; as you

listen to pain for real and work with your clients to improve their daily lives, your increase and make possible experiences of joy, kindness, care and connection. Your work is not an addition to be taken for granted, it is a fundamental necessity for living and dying well together and for responding to the increasing crises we face on a damaged planet. In particular, when 'mental health' and 'domestic violence' crises entwine, your expertise is necessary to increase our adequacy of understandings to the crises and to be able to respond, ethically in the provision of safety and support.

Thank you for enabling an other-wise telling of what happens at the convergence of the two crises and for enabling me to *think with* you in openings and spaces where *possibilities materialise.* You make many important differences in your work that change lives for the better, and as I move through the psy-disciplines now, I carry the memories of these *differences* with me and commit to enduring towards their recognition by the students, lecturers, psychologists and researchers I work with and for. The emphasis remains on those of us in institutions to transform the conditions of our work to connect with your caring expertise and to learn to *think with* you, to recognise your expertise for the knowledge it is.

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Appendices

Appendix A

To Whom It May Concern:

Sahaayta Counselling Services works with the New Zealand Police in a community collaborative partnership, providing early intervention to prevent family violence offending in Auckland City. Men who are bound by Police Safety Orders, or otherwise come to the attention of the Police for family violence related incidents, are referred to Gandhi Nivas for temporary accommodation, social work assessment and early intervention referrals. We provide services for all men referred to Gandhi Nivas and we also provide services to their families.

We are already working with Professor Mandy Morgan and members of her team on other research projects related to Gandhi Nivas, with our collaboration focused on improving the ways in which our services can enhance the safety and wellbeing of families in our communities. All members of the team have the support of our team's cultural advice to address any issues related to the diverse cultural and ethnic backgrounds of our clients that might arise in the course of the research.

We can confirm that there has been a consultative process in how this research project will be undertaken. We consent to members of her team accessing our services, including Gandhi Nivas houses in Otahuhu, Te Atatu, and Papakura, for the purpose of interviewing staff to provide accounts of their experiences working with clients who present with mental health issues.

Regards,

Sucharita Varma
Director, Sahaayta Counselling Services

Appendix B

Date: 03 May 2021

Dear Hazel Buckingham

Re: Ethics Notification - **4000024344 - Gandhi Nivas Safe House: Stakeholder experiences of responding to clients involved in family violence and mental health crises: A preliminary study**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Gandhi Nivas Safe House: Stakeholder experiences of responding to clients involved in family violence and mental health crises: A preliminary study

INFORMATION SHEET

My name is Hazel Buckingham and I am a Masters student in the School of Psychology at Massey University. I am supervised by Professor Mandy Morgan and Dr Leigh Coombes, researchers in the School of Psychology at Massey University who have been working in a research partnership with the Gandhi Nivas community since 2015 to develop a programme of evaluative research. This study is situated within that research partnership. You are invited to participate so that your experience of responding to clients involved in family violence and mental health crises who are brought to the Gandhi Nivas Safe House can contribute to a needs identification exercise within the community collaboration for reducing family violence in South-East Auckland.

Before deciding whether you wish to be involved in the research, please read this information sheet carefully to ensure you fully understand the nature of the research project and your rights if you choose to participate.

What is this study about?

This study aims to understand how stakeholders (including Sahaayta staff and New Zealand Police) experience the intersections between mental health and family violence crises events for men who come into the Gandhi Nivas residence while psychologically distressed.

Since late 2015, a research team in the Hearth Cluster at Massey University's School of Psychology has been working to conduct qualitative and statistical studies with the Gandhi Nivas community collaboration. An analysis of the New Zealand Police records of family harm episodes over 2014-2019 in Counties Manukau showed mental health and attempted suicide incidents were frequently recorded codes. New Zealand Family Violence Death Review Committee reports also demonstrate men using violence are often referred to mental health and addiction services (Short et al., 2019).

This research is to understand how these mental health crises may be impacting family violence response services within the Gandhi Nivas collaboration and to understand how the stakeholders experience these crises.

The study will involve gathering the following information from you;

- Your stories of your experiences working with clients who experience family violence and mental health crises

- Your understanding of the impact of mental health crises on family violence response services

- Your experience regarding stakeholder needs in order to respond to both crises effectively

What would you have to do?

If you agree to participate, you would need to be available for an interview with me to share your experiences on responding to Gandhi Nivas clients experiencing mental health and family violence crises. I expect the interview will last between 1 to 2 hours. I will have some open-ended questions that I would like to ask, but am mainly concerned that you have the opportunity to share your experiences. Interviews will be conducted privately and arranged at a place that is convenient for you. If you decide to take part, you can discuss your needs for privacy with myself or one of my supervisors.

If you agree, I will audio-record our discussion. I will transcribe your interview and remove all identifying information in the transcription process. Only myself and my supervisors (Professor Mandy Morgan and Dr Leigh Coombes) will have access to the transcripts. I will send you a copy of your transcript so that you can check it and make

changes to it if you wish. You will be asked for your consent before I use any extracts from the transcript in the research report and feedback. Audio tapes will be destroyed after you have checked the transcript. In the final research feedback I will not use any identifying information. I will do everything I can to ensure that you can speak openly with me in confidence; however, it is impossible for me to guarantee that no-one will find out that you took part in this research, especially since it is a project that involves others who work within the Gandhi Nivas Safe House collaboration. If you would like to share your experience of participating in the research, then you are free to do so, but we will not disclose your participation to anyone else.

All data collected will be stored in a secure location, accessible only to myself and my supervisors. After five years, all data collected for this research will be securely destroyed.

At the completion of the research, everyone who takes part will be sent a summary of the research findings.

What can you expect?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time until you have consented to the release of your transcript;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

Contact details

Hazel Buckingham
School of Psychology
Massey University
Based in Tāmaki Makaurau
Phone: ███████████
Email: hbucking@massey.ac.nz

Dr Leigh Coombes
School of Psychology
Massey University
Palmerston North
Phone: 06 350-5799, ext 85075.
Email: l.coombes@massey.ac.nz

Professor Mandy Morgan
School of Psychology
Massey University
Palmerston North
Phone: 06 350-5799, ext 85058.
Email: c.a.morgan@massey.ac.nz

Please do not hesitate to contact myself or my supervisors if you have any questions about this project.

> *This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researchers named above are responsible for the ethical conduct of this research.*
> *If you have any concerns about the conduct of this research that you wish to raise with someone other than the researchers, please contact Professor Craig Johnson, Director, Research Ethics, email humanethics@massey.ac.nz"*

Appendix D

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PUKENGA TANGATA

Gandhi Nivas Safe House: Stakeholder experiences of responding to clients involved in family violence and mental health crises: A preliminary study

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my transcript returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

I understand my data will not be archived.

Signature: _____ Date: _____

Address for returning transcript:

Full Name - printed _____

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Appendix E

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Gandhi Nivas Safe House: Stakeholder experiences of responding to clients involved in family violence and mental health crises: A preliminary study

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... **Date:** ....

Full Name - printed ....

Appendix F

**EVIDENCE — BASED —
POLICING · CENTRE · · ·**

**NEW ZEALAND
POLICE**
Ngā Pirihimana o Aotearoa

21 June 2021

Hazel Buckingham
Email: hbucking@massey.ac.nz

Dear Hazel

Research Application: EV-12-554 Gandhi Nivas stakeholder experiences of responding to clients involved in family violence and mental health crises: A preliminary study

Thank you for your interest in conducting research with New Zealand Police.

The New Zealand Police Research Panel have considered the above application and have provisionally approved this request subject to a number of conditions. These include the following:

a) Please sign the New Zealand Police Research Agreement and acknowledge that you will be undertaking the research under these conditions. If the Principal Researcher is employed by or affiliated to a New Zealand University, the University Research Office is required to sign and administer the Research Agreement along with the Principal Researcher.

b) It is important that you are familiar with and adhere to the New Zealand Police Policy for External Researchers.

c) Before requesting data, information or approaching resource that is not defined in the original research proposal, the Principal Researcher will need to seek written permission from the Director of the Evidence Based Policing Centre. This may require a variation or amendment to the research agreement.

Superintendent Rakesh Naidoo, National Partnerships Manager has agreed to be the point of contact at NZ Police and can be contacted by email rakesh.naidoo@police.govt.nz

I look forward to seeing the results from this work as I believe it to be important research that will offer new insights. I wish you well with progress and offer my support should you need anything further.

Yours sincerely,

Simon Williams
Director Evidence Based Policing, New Zealand Police
Lambton House, 160 Lambton Quay, Wellington

cc: **Supt Rakesh Naidoo**
        Rakesh.naidoo@police.govt.nz

EVIDENCE BASED POLICING CENTRE
Lambton House, 160 Lambton Quay, PO Box 3017, Wellington 6140, New Zealand
Telephone: (04) 474 9499 www.police.govt.nz

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