**New risks: the intended and unintended effects of mental health reform**

Stacey Wilson, Jenny Carryer massey University, Tula Brannelly University of Southampton.

**Abstract**

In crisis situations the authority of the nurse is legitimised by legal powers and professional knowledge. Crisis stakeholders include those who directly use services and their families, and a wide range of health, social service and justice agencies. Alternative strategies such as therapeutic risk taking from the perspective of socially inclusive recovery policy co-exist in a sometimes uneasy relationship with mental health legislation. A critical discourse analysis was undertaken to examine mental health policies and guidelines, and we interviewed service users, families, nurses and the police about experiences of accessing services. For those who attempt to access services early in crisis, as is suggested to lead to a better outcome, provision of services and rights appear to be reversed by an attempt to exclude them through practices that screen them out, rather than prioritising a choice in access.

Key words: mental health; discourse; health reform; critical theory; Foucault.

**General background**

 The introduction of contemporary mental health legislation from the late 1980s in countries such as the United Kingdom (UK), Australia and New Zealand (NZ), resulted in redevelopment of crisis mental health services. Changes included closure of large psychiatric institutions and the introduction of community orientated crisis care underpinned by new mental health acts. These changes have consequences for service users, families, mental health professionals relating to interpretation of mental disorder and who is responsible for safety and communication during the process of assessment and subsequent treatment or discharge. National inquiries (O’Hagan 2006; Mind 2011; Rosenberg 2012) stated that the provision of mental health care is inadequate, yet little detail is provided about the state of crisis intervention services. The impact of deinstitutionalisation is only now becoming apparent. There remains little evidence about how the changes to legislation have impacted on policy and the practice of crisis work or how mental health professionals have adapted their approach.

 Current mental health strategies were established to guide services during the development of community care (Department of Health (DoH) 2011; Mental Health Commission (MHC) 2012). Policy and legislation suggest services are to be delivered in the least restrictive environment with the least coercion and with an increased variety of home based treatments (DoH 2014; Ministry of Health (MoH) 2013; Council of Australian Governments (COAG) 2012). Broad changes to service implementation because of policy developments (MoH 2013a), include increase in access and services provided (DoH 2011), alongside workforce developments for reorientation to community interventions.

**Methodology (theoretical perspectives)**

 Foucault developed a historical analytical technique termed genealogy. The purpose of a genealogy is to examine the connections and intersections between discourse, power, knowledge, and the production of the subject. Foucault (1979) dispensed with the constituent subject and focused on the ways in which language is involved in the constitution of the other. This paper includes discussion on the ways that people are made both objects and subjects within discourses, strategies and technologies of the self through the process of governmentality. The use of discourse in this study is as a philosophical term, referring to perspectives of knowledge, within epistemologies that legitimise certain ways of acting and being. According to Foucault (1977) discourse encompasses ways of acting and explaining action in society. An example of discourse is the bio-medical discourse that is dominant in health care (Rose 2007). Underpinned by scientific ideology, biomedical discourse provides possible ways to understand bodies, patients, doctors and nurses (Rudge and Holmes 2010). Personal recovery discourses (Barnes and Shardlow 1997; Pilgrim 2008), seek to explain experiences of self-determination of service users (Deegan 2005), rights to social inclusion (Pilgrim 2005) and citizenship (Mental Health Advocacy Coalition (MHAC) 2008). Self-determination, social inclusion and citizenship are impacted as a result of the experience of mental distress.

Governmentality in Foucault’s view signaled the change in technologies of and attitudes towards governing (Rabinow 1997). The change moved to an emphasis on the State’s ability to manage its resources, including the population, economically and efficiently. An aim of governmentality is to reduce financial liability of the State through the argument that citizens are responsible to each other and to the State to be as self-sufficient as possible. Through governmentality citizens are regulated in strategies and technologies to monitor and improve their contribution to society (McNay 1994). As a result subjectivity and normativity come into question.

Foucault’s subjectivity replaces the notion that our identity is the product of our consciousness or self-governing self. Instead, individual identity is presented as the product of discourses, strategies and technologies (Cruikshank 1996). Through the notion of subjectivity, normative judgments become a way to assess and monitor the actions and attitudes of individuals according to a norm or average within a population. Normative judgments work throughout various institutions, for example, in prisons, schools, health-care and throughout society, in attempt to determine norms or standards and conformity in what is judged as right or wrong within a dominant discourse (Loughran 2011).

The term subject has two meanings: The first meaning is to be subject to someone else by dependence or control. Secondly, subject can hold meaning as being tied to one’s own identity by consciousness or self-knowledge (Winch 2005). Foucault (1994) suggested there is a need to recognise both the historical political influences upon health service users and the move toward health becoming less in the control of those accessing and providing services. Strategies, technologies and tactical aspirations of particular authorities shape beliefs and the conduct of a population (Holmes 2002). Rose (1996) argued that one main feature of technologies of self is that of expertise.

Expertise is the grounding of authority in a claim to scientific and objective reasoning that creates a distance between self-regulation and the state within a liberal democracy (Hansen 2009). Expertise can move and be moved within a political argument in particular ways and produce a different relationship between knowledge and government. Furthermore, in operating through a relationship with self-regulating abilities of people, expertise becomes the authoritative and plausible claim to science and binds subjectivity to truth and subjects to experts.

This paper includes analysis of relevant mental health risk management policy and legislation that unnecessarily marginalise service users and families, and impact on the practice of nurses involved in this study. Technologies of risk assessment and diagnosis are specifically critiqued. Risk management and the therapeutic relationship both exercise surveillance in crisis intervention. Through risk technologies, fear and threat have a disciplining effect between services users, health professionals, families and the police.

**Methodology (materials and method)**

This study gained ethical approval from the National Ethics Committee as well as locality approval from Health Authorities, service user and family organizations and the NZ police. Analysis is centered in converging and competing discourses, strategies and technologies in the field.  In order to develop a position to discuss a range of converging and competing discourses, perspectives were sought from ten people who have accessed crisis services, ten families who supported service users, ten crisis mental health nurses and senior members of the NZ police.  Perspectives of the participants were gained through individual interviews using open ended questions and focused on their experience of a mental health crisis.  Analysis of the published research and grey literature took place in between interviews, data analysis and during the writing process.

Aims of the study were:

* Collect and analyse published research and grey literature relevant to the intentions and implementation of mental health crisis intervention.
* Explore the knowledge and practices of crisis intervention from the perspectives of service users, families, mental health nurses and the police.
* Develop a position to explore a range of possible interpretations that services could utilise to engage people and their families/significant others experiencing crises.

Discourse is considered a representation of some particular part of the world that forms a particular perspective. Equally, in this discourse analysis we identified the particular parts of the world, the main themes, and identified particular perspectives, angles or points of view about them. A list of questions adapted from the work of Parker (1992), and Finlay and Ballinger (2006), were used as a guide to first consider the research data, and the analysis of the discourses associated with crisis intervention (see Table one).

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| 1. What kinds of visual images are conjured up by the text?
2. What kinds of people are present in the world alluded to or described within the text?
3. How about the people least likely to be associated with this world?
4. What are the important things, ideas and/or tasks in the sort of world created by the texts?
5. What type of world is conjured up by these text?
6. How are particular sorts of individuals, organisations and systems legitimised and strengthened through the operation of certain discourses?
7. How do discourses work together to sustain particular realities and truths?
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**Table one: Initial analytical questions**

Following the analysis using the questions above we worked through questions adapted from the work of Fairclough (2003) and further developed by Neville (2005), that we used as a guide to focus on further Foucauldian perspectives of the analysis (see Table two).

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| 1. How is power exercised and by whom?
* In what ways are disciplinary power represented in the text?
* What are the dominant discourses?
* What are the subjugated discourses?
* What are the resistant discourses and how do they disrupt dominant discourses?
* How do the resistant discourses facilitate alternative ways of speaking about mental health crisis and intervention?
1. What are the institutional practices and how are they supported or modified by other discourses?
2. How have dominant discourses come to occupy a privileged position in relation to mental health crisis intervention at the expense of subjugated discourses?
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**Table two: Foucauldian perspective to analysis**

Poststructural research relies on theoretical analysis, here Foucauldian analysis, rather than theory building analysis (Hamilton and Manias 2008). Analysis of the data including interviews and written text focused on identifying discursive practices. Hepburn and Wiggins (2007) argue that discursive practices are the micro-politics of language use and actions. In this study, data analysis centered on identifying discursive practices in the data, on the basis that practices are imbued with power from the social, historical and political context of crisis intervention using the questions above to offer different and alternative perspectives.

**Findings**

Policy has been reformed in conjunction with implementation and amendments to legislation, for example, the New Zealand Mental Health Act (MHA) (1992), United Kingdom Mental Health Act (UKMHA) (2007) and the Victoria Mental Health Act (VMHA) (2014). In NZ acute and crisis services existed prior to 1992 legislation, however with its introduction new roles and responsibilities for mental health nurses occurred. Internationally, mental health legislation prescribes inherent responsibilities in the roles but does not describe or discuss the knowledge and skills that relate to the undertaking of crisis work, risk assessment or engagement of service users and their families. Therefore knowledge is assumed to be borne of professional disciplines. Practitioner’s knowledge and skills are developed through technologies of normalisation and individualisation within in situ training of professionals working in crisis services. Clinicians are required to assess people using the criteria outlined in legislation, which includes identification of mental disorder as well as dangerousness. The public perception is that crisis services are there to keep the public safe from people they perceive as threatening (Star et al. 2005), and therefore that clinicians are able to implement the legislation.

 Tensions can be created when attending to the uncertainty of a person’s experience of distress during a crisis and also appearing in a political sense, to attend to the public demand to keep the person safe. Foucault’s analysis concerning the technology of the self considers how people manifest themselves as subjects and he distinguishes between subjection and subjectification. Subjection is when an individual or collective is proclaimed subject within a specific discourse and the individual or collective is given a specific position in the discourse from which it can speak and act meaningfully (Akerstrom-Anderson 2003). Alternatively, subjectification is played out when a person or collective has not only been made the subject, but also wishes to be so.

 The purpose of crisis services is viewed differently by clinicians and by people who want to access services. One aspect under examination is not the level of distress the person presents with but their ability to make rational decisions about themselves and their behaviour. Through analysis of the self and power, ways that autonomy is suppressed become visible. However, as Rose points out:

 [i]t is not a matter of laminating the ways in which our autonomy is suppressed…but in investigating the ways in which subjectivity has become an essential object and target of certain strategies, technologies and procedures of regulation (1992, 52).

Professionals from other agencies such as child protection services, the police and non-mental health clinicians also have a differing view of what crisis services can provide.

For the NZ police the crisis team is a front line service to address the assessment needs of any member of the public appearing to be mentally unwell. Sergeant A, an experienced police officer, outlined a common pathway to accessing services, he stated:

“We get a call from the public so we go down and get them and take them into custody and if it looks like they have some kind of mental health issue we bring them back here [police cells] and get the nurse to assess them. Or otherwise someone calls us and says ‘my son is going nuts’, we go out and find they have a past mental health issue and he’s in that phase where he’s just gone off his tree, so we lock him up and get the crisis team to come out”.

Sergeant A spoke about likening the person in crises to a unit of service requirement or a job waiting to be dealt with. DuPont and Cochran (2000) suggest that police-officers resist involvement with the crisis team because they resent being thrust into the role of gatekeeper to social services and they see this as impairing their ability to carry out their principal task of law enforcement. However, participants in this study and the literature concur that many individuals, particularly ‘nuisance offenders’, for example people who are homeless, intoxicated or seen to be displaying disorderly conduct, are best managed through the diversion to crisis services rather than detention in police cells because they are perceived to be in need of help and requiring access to services (Lipson et al. 2011; Watson et al. 2004).

 Mental disorder cannot be associated with a person without reference to “a statistically constructed normal case” (Allan 2012, 94), in the same way that a person is not a criminal without reference to the law. It is questionable then, as to how a biomedical discourse of norms, despite claims of scientific bases, can be seen as any more true to nature, or physically true than any other explanation. All norms are artefacts of disciplines (Hook 2007) that measure them, and they have no physical being or reality apart from that practice. Mental disorders are situated within a broad social context as well as a biological condition. According to Allan, impairment of the mind, “like disability, is not something missing, not a lack or absence it’s something added, an unasked-for supplement contributed by disciplinary knowledge and power” (2012, 94).

 Foucault defined discipline as “the type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of applications, targets” (1979, 215). Institutions of mental health care and modern-day community services such as crisis intervention are an example of omni-disciplinary techniques insofar that they monitor, study, teach, detain/punish and train patients in the hope of making them into useful or less mentally disordered individuals (Holmes 2001; St-Pierre and Holmes 2008). As well as defining discipline as a type of power, Foucault suggested, “discipline produces subjected and practiced bodies, docile bodies” (1977, 137). In our conversation Chas, a service user recalled how a variety of services looked over his situation to determine what agency was best to deal with him, he stated:

“Trouble with me was that I didn’t fit a criteria, ED wasn’t interested, my GP said it was out of his hands, the cops didn’t want a bar of me and when the crisis team was called they said it was a long term problem…what do you do, you’re in their hands aren’t you?”

Foucault suggests, “discipline makes individuals; it is the specific technique of power that regards individuals both as objects and instruments of its exercise” (1977, 227). This account of people being the objects of various techniques and practices strengthens Foucault’s account of power. People in crisis are not only the objects of various technologies, for example, documentation, mental state examinations and risk assessment, but also they are then subjects in the workings of disciplinary apparatus (Evans 2010). Figure one, is a visual representation of the dominant discourses analysed in this study.

**Figure one: Discursive constructions within crisis intervention**



 Subjects in crisis are taught to be productive, self-responsible, aware of their impact on others and self-impose correction (Cruikshank 1996), to minimise the work of surveillance and risk management that they create through their mental disorder. Foucault (1982) suggested the subject is to be understood as a formation as opposed to a living thing. In other words the form or subject is not constant even when attached to the same individual. Understanding Foucault’s notion of the subject involves recognition between two different but interrelated meanings attributed to the subject.

 Foucault suggested that human beings are made subjects, namely, they are made subject to. In other words, Chas is made to be subject by others to control and dependence. The second meaning is the subjective identity, which is, what or who the subject understands is produced by being tied to a given identity through self-knowledge. Elaine, a family member participant and long-term partner of Chas, demonstrates that subjective identity is extended to family members also. The expectation is that families enact the discipline by adopting the strategies offered by the discipline as a support mechanism. In the quote below, Elaine talks about the need for Chas to self-manage and contain distress. She stated:

 “I’ve had to tell him [Chas] you have this mental thing and you have to start managing it, it’s not going to go away…and I need to take a deep breath myself, I need to keep it together – let’s face it, if I don’t who will?”

Subject positions can be understood as ways of being within a particular social context and can also be understood as spaces from which one speaks and observes in a discursive formation. Conscious subjectivity is acquired through discourse according to Weedon (1987) and is unstable in the sense that subjectivity is constantly a process.

The changes to service configuration and demand for differing practice orientation of clinicians working in crisis teams have occurred over a period of time. Since the late 1990s, policies emphasised service user autonomy and action (DoH 2014; MHC 2012). Although policies and legislation shape professional interventions with an aim to be recovery orientated, a potential consequence of change has meant a shift to an individualisation of risk. Implementation in practices has meant that users of services must be vigilant about safety and risk in their own recovery and responsibilities toward others (Peron et al. 2005). An individualisation of risk permeates throughout law and policy.

 Crisis intervention practice has become increasingly focused on the assessment and management of risk to and posed by service users (Szmukler and Rose 2013). Deinstitutionalisation and the uptake of community services has produced a discourse of accountability in strategies such as regulatory control via policy reforms, practice audit, quality driven outcomes and an increased demand for mental health related services (Muir-Cochrane and Wand 2005; O’Byrne 2008). Furthermore, the problem of risk has raised a problem of compliance and the use of medications as evidenced in the data below from MHN Pam, she stated:

“I think about this a lot…on the one hand we don’t want to be creating dependency on services, especially hospital, but we are a social service. Trouble is home isn’t always a safe place for people… But it does take time to deal with people in the community, much easier to put them in hospital or send them off with pills and loads quicker for us, but if anything goes wrong who does everyone blame? The crisis team of course”.

Service changes require a higher level of need, acuity and complexity among the people who access, exacerbated by reduced inpatient care and early discharge practices (Chaplow 2011; O’Brien et al. 2007). Thus, the management of risk has become increasingly pivotal to crisis mental health assessment, intervention, documentation and interaction with people. Power and control acts by swallowing up alternative definitions and concepts about the experience of crisis, mental illness and other human conditions and facilitates the silencing or discrediting of alternative interpretations or ideas (Lakeman 2010).

Psychiatry utilises strategies such as the MHA in order to promulgate the object of crisis and its causes and therefore own the treatment and right to decision making, through categorisation and homogenisation of people experiencing mental distress. Crisis intervention within NZ has positioned medicine as an integral part of health care within general hospital settings and as leaders within mental health services. Coinciding with psychiatry’s leadership of crisis services and the increased demand for mental health services, the government introduced the requirement of outcome measures for all mental health service delivery (MoH 2013; Rosenberg 2012). The State also prompted the implementation of outcome measure to address a perception that community mental health services continued to keep people on the books unnecessarily (Davis 2013). The social and economic implications of mental illness began to be documented.

 Technologies such as triage and mental state exams seek to define and classify symptoms of social behaviour and human experiences, through so-called objective and scientific means. Through technologies, professionals and those identifying the problem of risk become known as experts with their own specialist language (Fisher and Freshwater 2013). Expert discourses in crisis intervention and long-term mental health care create the need for deficit-targeted interventions and the expectation that service users will respond accordingly to treatment regimes and professional advice (Mezzina et al. 2006; Rose 2007).

Consequently, people who might meet the criteria for such authoritative interventions find themselves dictated to by a power to transmute their identity, to refashion expectations and views of others in their life including instructions from professionals to limit certain aspects of their lives to what is deemed reasonable to do and be (O’Byrne 2003; Saleebey 2005). Further to consistent dissatisfaction verbalised by each of the nurse participants, MHN Ross expressed frustration that the focus on a risk management audit trail for health and social services meant those agencies use the crisis team as a dumping ground for unwanted responsibilities.

He stated: “… all sorts of agencies are getting in on shoving their work onto us…when you talk to GPs…in ED nurses and other ward nurses, they say ‘oh we need an opinion’, so what opinion do you need, um well we need you to determine the risk level, oh ok um yeah I’ve just seen the person, the person is not suicidal…people are worried about having to cover themselves, the whole general side hospital cannot function…ICU ring us saying can you give us an opinion on this person? So we say what’s the problem, we go and assist them because they [service user] might have taken an overdose or might have expressed a desire to die then after we assessed the person and we say they are safe to go, but now people want to cover themselves. The police are worse, somebody comes in, they’ve taken three panadol, they’d ring the CAT [Crisis Assessment Team] team and say ‘what’s the risk’ and I say ‘there is no risk, you can take two or three panadols if you want’. What the police are doing is just to cover their arse so they say I want you to come and see the person. Cause what we ask when we triage, is there a mental health problem…‘No’, why do you think they are mentally unwell? ‘Oh I don’t know’ but I think you’re the expert I want you to come and determine the risk”.

Intervention to prevent loss of life is another aspect of State control that health and social services are required to perform. It is a duty of care for services to intervene to prevent loss of life (Australian Mental Health Commission (AMHC) 2012; MHC 2012; DoH 2011).

 Rendering crisis subjects to pathology of risk may well be brought about through technologies of normalisation and individualisation within the training of crisis clinicians. According to Foucault (1975) techniques of normalisation and individualisation are developed through so-called scientific or empirical means to separate out professional knowledge from personal knowledge. Foucault was most persuasive in his description of how, through supposed knowledge of the normal case, differences among people became targets of power (Allan 2012). Medicine identified certain problematic emotional experiences and expressions of behaviour as a way in which people are suggested to be physiologically malfunctioning and in principle, no different from any other dysfunction of the body (Cutcliffe et al. 2013). MHN participants describe a binary created by the joining together of biomedical and accountability discourses. However, Perron (2013) argues that too often a nurse-service user relationship is portrayed as private and apolitical, which detracts nurses from the broader context of nursing and health care and their ability to influence and shape the ways they can undertake their professional practice.

**Discussion**

Risk management has received considerable attention (O’Byrne 2008). The impact of risk discourse has been far reaching and the growth and knowledge in understanding of what risk implies in a mental health setting has been a popular pursuit of researchers. As a concept within policy, the definition and management of risk is the restoration and redress of social inequalities and the meeting of needs of the citizens as a primary function of a welfare state (Dean 2000). Phillips (2004) suggests that the function of risk management includes determining how and to whom resources should be rationed, including prioritisation of responses to service users and accountability for all services. Lupton (1999) argues that risk management, through the regulatory power by which groups and individuals are monitored and managed, directly impacts upon service users. Furthermore, through ongoing risk analysis undertaken by institutions and the professionals who work within, populations are understood to be of risk or at risk.

Significant positive results of risk management practices such as prolonged life expectancy, social protection for those who are unknowingly exposed to danger, and reduction of symptoms have been identified (Szmukler and Rose 2013). This normative stance ignores that certain people are thereby practiced on in certain ways. In the most part, service users have been excluded from contributing to the discourse of accountability or development of risk management practices within mental health care (Byrne et al. 2013). Service user discourse on risk is minimal, as are perspectives on positive risk taking. Their perspectives about risk are often disregarded by the predominant medical and bureaucratic discourses of mental disorder and liability (Szmukler and Rose 2013). Furthermore, without inclusion of user perspectives concerning accountability for risk assessment and management, professional and social implications of risk cannot be fully addressed. This is particularly relevant given the impact of policy directing an individualisation of risk.

The individualisation of risk (Beck 1992; Beck and Beck-Gersheim 2002) suggests a process whereby individuals are increasingly encouraged to assume lower thresholds of risk acceptance, to be more accepting of their own actions now and to integrate a kind of self-distancing regard for their conduct in the face of future uncertain outcomes. Dean (1999) influenced by Foucault’s notion of governmentality, suggests that over time, risk has been transformed from inscripted calculations and anticipatory projections toward future outlooks and conducts of everyday life through individualisation. Consequently, people are enlisted in the ethical government of their own actions through the individualisation of risk (Honneth 2004).

The power of risk policy develops through relationships that subjects have with law and policy. This involved the discursive construction of risk management (see Figure one) through accountability discourse, where risk is generalised, dispersed and insinuated into the practices of everyday life of people (Fisher 2012). The individualised risk appraisal requires the subjects involved to constantly re-calculate problems to which they are unendingly required to attend. In the acute mental health setting, attempts to control the actions and behaviours of service users and nurses, is sometimes more about meeting the fiscal need of the organisations rather than the needs of those accessing services (Crowe and Carlyle 2003).

 It is outside the scope of this paper to discuss every issue of concern in regard to why people might access crisis services. There are however serious health and social issues which nurses working in crisis services deal with daily, including that of assessment and management of risk toward self and others (Szmukler and Rose 2013). Every year in NZ for example, approximately five hundred people die by suicide and five times as many people will be hospitalised after making an attempt on their life (Statistics NZ 2014). There is an abundance of policy and national strategies, which describe factors relating to suicide prevention and workforce development for clinical staff (MoH 1998; 2013a).

 A key recommendation of suicide prevention strategies is that practitioners adhere to guidelines that aim to provide a standardised set of directions. Practitioners are to demonstrate evidence-based interventions resulting in the reduction of attempted suicide, deliberate self-harm and suicidal ideation. However, according to Cutcliffe and Stevenson (2008), the policies directing such guidelines may result in stigmatising risk management approaches, defensive practice and potentially coercive behaviour by mental health nurses. They argue, “as a result, the problem of suicide is seen to reside in individuals who thus need to be controlled, contained, and/or managed, and this inevitably means controlling, and/or containing and/or managing the risk” (2008, 345).

Clear links exist between nursing surveillance and Foucault’s (1977) work on discipline (Holmes et al. 2008; Perron, et al. 2005). Foucault wrote that the success of disciplinary power “derives no doubt from the use of simple instruments; hierarchical observation, normalising judgments and their combination in a procedure that is specific to it, the examination” (Foucault, 1977, 170). Some authors argue against the idea that surveillance is everywhere and make a distinction between repressive and positive power (Henderson 1994; Holmes et al. 2007; Gagnon et al. 2010). This argument suggests that positive aspects of power can be harnessed in order to empower people experiencing distress. Potentially, Foucault may have agreed given his suggestion that “to say that one can never be outside power does not mean that one is trapped and condemned to defeat no matter what” (Burchell et al. 1991, 141). For that reason, the potential of crisis intervention practices, which include surveillance as a means to work with those experiencing crisis may be of use. Nevertheless, such practices create tension and potential challenges for nurses.

 Perron et al. (2005) argue that nurses contribute to social regulations through a vast array of diverse political technologies and occupy a strategic position that allows them to act as instruments of governmentality. Through technologies, such as mental state exams, Duly Authorised Officer (DAO) consultations and tick box style risk management, crisis nurses promote compliance behaviours in service users in the form of monitoring and within mechanism of control and coercion, of which are sanctioned by the public and seen by them as a gain in health behaviour and self-management. The promotion of health education strategies in policy documents to empower service users is widely suggested as a way in which clinical staff can promote recovery but such technologies are also there to reduce the demands on social service resources.

**Conclusion**

There is subjugation of the voice of service users as a valid form of knowledge, an uncritical acceptance of the need for risk led service provision and a lack of understanding of the purpose of crisis intervention as a site of control rather than care. In this paper we have argued that biomedical discourse has developed and converged with accountability discourse through strategies such as mental health legislation and policies. We have discussed how people experiencing crisis and those who work alongside or on behalf of them govern themselves in order to reduce liability on the State. Whilst being subjected to disciplinary measures, service users, nurses and family members are also required to participate in the workings of the disciplinary apparatus of mental health services. Those in need of access are required to meet the needs of the service in order to be constituted differently and seen not to need to use the services anymore. Furthermore, the extent of interventions could be seen to be promoting self-containment of behaviours.

In order to self contain, the person needs to self monitor for signs and signals that indicate any changes in mental state and alert services so that any potential harm can be avoided. This can be seen as self-surveillance, and other members of the person’s community are also asked to provide surveillance on behalf of services. The goal of this governmentality is to install within individuals an obligation to the state and to each other to self-manage and to be contributing subjects actively involved in the production of self-governing citizenship.

This raises a need for a broader understanding of choice within the discursive construction of expertise, including who has the social and cultural capital to decide on resources and potential widening of options of interventions. Service users and their families want professionals whom they can trust to do what is required. Moreover, the tension between normalisation and medicalization experienced by mental health practitioners is a meaningless dichotomy that can be eased by practitioners engaging in issues of authentic relationships, in order to balance the scientific, economic and social discourses to which they are subject. This includes being prepared to critique one’s own role and actions so to create an opportunity to pay attention as to how our practices become engrossed by power/knowledge regimes. Scrutiny of the process of knowledge production in crisis intervention can provide an opportunity for resistance in the current status quo contributing to conditional citizenship.

 The implementation of strategies such as contemporary mental health legislation, risk management policy and community policy shaped a newly created field of crisis intervention within Western mental health services. This paper has been about analysis of the discursive practice of being labelled risky and the resulting divergence in law and policy, which creates for nurses the obligation to manage a tension between medicalisation and normalisation.

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