Mental health crisis intervention: A discourse analysis involving service users, families, nurses and the police

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Abstract

This research is a Foucault-influenced discourse analysis, which explores the field of Aotearoa New Zealand mental health crisis intervention, with the goal to challenge current practices. The study takes place in the context of changing access to mental health crisis services, following the implementation of the Mental Health Act (1992) and subsequent policy, regulation and practice development strategies.

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 9 people who have accessed crisis services, 8 family members who have supported service users, 9 mental health nurses working in crisis services and 2 senior members of the New Zealand police. Analysis of the published research and grey literature took place in between interviews, data analysis and during the writing process.

The overarching findings are that crisis intervention is affected by four predominant discursive constructions. These include mental disorder, risk management, expertise and uncertainty. The discursive constructs are influenced by three dominating biomedical, accountability and social development discourses, working together to produce power/knowledge of the people involved in crisis, whilst simultaneously subjugating a personal recovery discourse and the potential of uncertainty.

Consequently, participants bear disproportionate amounts of responsibility during a mental health crisis in which they are held accountable for much of what occurs in the clinical and community setting. They have limited control over the decisions that affect care, and largely, the way services are delivered. In order to disrupt structural and systemic inequities, I argue that self-reflection is required to attend to the ways that the experiences of people involved in a mental health crisis affect and contribute to maintaining the status quo. Attending to the possible stages of resistance surrounding the dominating discourses allows the potential for building authentic relationships within crisis intervention. Foucault's framework of ethical practice is utilised to counter conditional citizenship and redefine responsibilities in the field.

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Chapter one: Introduction – framing the study

1.0   Introduction

Chapter one of this thesis begins with the background information, which situates my role as a researcher investigating the discourses involved in mental health crisis intervention. Discussion includes law, policy and practice, which influence the production of crisis intervention services.   An overview of the literature and background provides context and justification to the field of inquiry in this study.

The production of certain individuals, organisations and systems within mental health crisis services are legitimised and strengthened through the operation of particular discourses. Crisis intervention in Aotearoa New Zealand (NZ) involves strategic relationships between mental health and social service agencies through which power operates. Through interactions of power and resistance, discourses sustain particular realities and truths about the subjects involved. In this thesis, the operation of power and resistance are discussed in relation to mental health service provision. I describe the influences of poststructuralism and Foucauldian theory and how they frame the research question and aims of this study. I conclude this chapter with an overview of how the thesis is structured.

1.1   Background to the study

I want to begin with a declaration of my position as the writer of this thesis. I am a Pākehā woman who is 42 years old and I have been a mental health nurse for 21 years. I began my nursing career as a new graduate registered nurse during the devolution of NZ psychiatric [hospital based] care to community mental health services. In 1994 I trained as a crisis nurse *in situ* as services developed and worked in a variety of crisis teams in urban and rural NZ over twelve years.   More recently I have had a predominantly teaching and research role within the polytechnic and university education systems. I facilitate learning for undergraduate nursing students in class and clinical practice. Within the postgraduate nursing programme I work alongside registered nurses and other health professionals teaching advanced mental health assessment and I supervise research.

When I refer to crisis training being *in situ* I mean that from the mid 1990s onward, there was no particular formal education for crisis workers. Learning how to work with people and their families experiencing a mental health crisis involved minimal reading of a textbook on crisis intervention. Mostly, learning the skills involved came from my interaction with people in practice and to a large degree through observation of and reflection on others and my own experiences.

When I began practice as a crisis nurse I liked it straight away. I had become disillusioned with working in the ward setting mostly due to the decrease in therapeutic interaction able to take place in the increasingly crowded small wards now attached to general hospitals. Nearly all of the large institutions were closed and there were significant numbers of people who had been in long-term inpatient care being moved out into supported accommodation in the community.

The inpatient wards served more as a placement of containment and nursing interaction was largely observational. Therapy groups and undertaking individual and family work in the inpatient setting had been replaced by a high turnover of brief admission to the unit, with an emphasis on the administration and monitoring of psychiatric medications. The inpatient care still operating was significantly understaffed due to the mass exodus of experienced nurses through retirement and redundancy, when hospitals such as Lake Alice, Porirua, Cherry Farm, Seacliffe and Oakley closed.

The government strategy to have acute inpatient units attached to general hospitals had been rapidly accepted as the mode of care in the context of an expanding array of community mental health services and crisis intervention teams, which were being set up in each of the health authorities. It was good timing for me to gain a position with a newly formed large urban crisis team that had managed to secure a mixture of nurses with both community experience and years in the field of mental health nursing.

The work of the crisis team also suited me. To a large extent crisis nursing was a short-term interactive form of practice that involved negotiating priorities, containment and stabilisation of emotional distress and engaging the people involved in some form of change. An ability to quickly form rapport with people, be they the user of services, their family, referring agencies, the police or the public is an

essential skill of crisis work. The need to form trust with others and be seen to be reliable and competent is also a means to negotiating safety for all and a fair outcome for the service user, their family and/or those who had accessed services.

Crisis interventions included skilled communication, recognising the right issues and rapid decision making to put into place structures and supports for the person in distress. In the earlier days of crisis work in NZ, structures and supports in the community were not necessarily available. Resources consisted mainly of the interpersonal ability of the crisis nurse actioned through telephone counseling, home visits, short term crisis counseling until an ongoing clinician could be sourced from community mental health services or outside agencies; access to medications through a psychiatrist, administered and monitored by the crisis team; or admission to an acute mental health ward.

Services were based on a convergent model of crisis intervention including the process of triage, a process of ascertaining urgency and prioritising referrals; mental state and psychosocial assessment; screening of risk to self and others; making a plan to stabilise emotional distress; short term therapeutic interventions, including medication if required; and networking the person in crisis into ongoing support and follow up services for them and their family.   As a mental health nurse (MHN) I was also expected to provide information, education and support to service users and families about other mental health help available in the community and practical assistance to health providers and the police when they requested.

When I think about my experiences as a crisis nurse I do so with quite mixed emotions. At times I remember the excitement and unpredictable nature of the work and at other times, the heavy feeling of responsibility and concern about the safety of others and of myself.   Emotions as a crisis worker are the full array – excitement, anticipation, joy, relief, sadness, fear, uncertainty, guilt, frustration, satisfaction and hope. Emotions are a big part of crisis work whether you are working with service users or families to help decipher how they might manage their thoughts, feelings and behaviours or how as a nurse you recognise and manage your own emotional competence (Wilson & Carryer, 2008).

Following the devolution of hospital based services; development of crisis and community mental health services was in a context of legislative and policy

change within NZ health. Prior to the introduction of the Mental Health (Assessment and Compulsory Treatment) Act (MHA) in 1992 any person who met the criteria under the act and was deemed to be mentally unwell and requiring treatment was detained under the 1969 Mental Health Act in a psychiatric hospital.

The Mental Health Act (1969) provided only for compulsory admission and detention to a psychiatric inpatient facility. With the introduction of the MHA (1992) a new mandate for a *least restrictive environment* of compulsory assessment and treatment came about. Following international trends, the NZ Government passed new legislation and moved the majority of funding and provision of mental health care on a voluntary and compulsory basis to the community. Small inpatient mental health facilities with 10-20 beds were built on general hospital campuses and resources such as staff were dispersed within community mental health service delivery (Mental Health Commission (MHC), 2007).

Under the MHA (1992) new roles and responsibilities for mental health staff were designated. These particular duties were designated primarily to nurses and doctors within community mental health care and included legally appointed lawyers and health administrators to undertake certain roles and responsibilities concerning the implementation of the Act. In the most part, the MHA (1992) signaled a philosophical shift to a rights based approach and the intention or spirit of mental health legislation, to provide services within the least restrictive environment. With the closure of psychiatric institutions the ability to send away and detain people experiencing mental illness was beginning to be viewed as morally and socially unacceptable.

Crisis services were mandated through legislation and mental health policy to undertake the duties of the Duly Authorised Officer (DAO), a role designated under the MHA (1992). According to the MHA (1992):

> DAO's are the front-line operators of the Act. They are the specialist mental health professionals who the public are most likely to have first contact with, and consequently DAO's may need to provide information and advice on a very wide range of mental health concerns (MoH, 2000b, p. 7).

Crisis teams from the 1990s became the point of entry for all urgent [need to be seen that day] mental health assessment. Services were required to take referrals from any person who was mentally distressed or any person who was concerned about the

mental distress of another. Referrals came from potential service users, families, general practitioners, accident and emergency departments, general hospital wards, prisons, the police, school teachers, counselors, family members and a raft of individuals concerned about the mental state or problematic behaviour of someone for whom they were concerned or responsible.

Crisis services became a new point of easy access to information, advice, assessment and treatment for anyone to contact in the community and we were swamped. I can recall many occasions in practice in those formative years where my 'partner' [another crisis nurse with whom I would have been paired up, to undertake a crisis assessment] would be driving to the next assessment whilst I, sitting in the passenger seat, was writing up notes on the last person seen and talking to the psychiatrist back at the crisis rooms about the outcome on one cell phone, with the other phone ringing with calls from the next person asking for assistance!

1.2 The process of searching research and grey literature pertaining to crisis intervention

The search strategy in this study involved reviewing articles, government reviews, policy and other publications and a variety of books published on crisis intervention. I sourced peer-reviewed literature obtained from databases, using broad criteria for inclusion. Data bases including the Cochrane Collaboration, EBSCO host, Science Direct, ERIC, Medline and PsychArticles, CINAHL Plus with full text, Social Services Abstracts and Sociological abstracts were searched for articles using the search words: 'crisis', 'crisis intervention', 'mental health crisis', 'psychiatric crisis' and 'crisis AND nursing'. The database DISCOVER has been used on an ongoing basis to update the literature review at regular intervals.

The search was narrowed down to abstracts that indicated the primary aim of the research had relevance to the intentions and implementation of mental health crisis intervention. After the initial broad search I further reviewed articles concerned with repeat issues raised in the previous literature. Roles, responsibilities and ideas that were raised pertaining to mental health nurses, other health professionals, families and services users and the police were further explored in the subsequent literature. A specialty such as crisis intervention has also developed its own so-called empirical base including research publications for example: *Journal of*

Traumatic Stress, Aggression and Violent Behaviour, Journal of Interpersonal Violence and Crisis Intervention. Publications in specific crisis intervention journals are dominated by a psychological construct of crisis intervention, for example, a loss of motivation or negative thinking associated with distress. While in contrast general mental health nursing and allied health publications emphasised the biopsychosocial components of practice in the area, for example, irritable mood associated with bodily dysfunction such as insomnia.

Several particularly useful government and mental health web sites were utilised to obtain reviews and documents concerning crisis intervention within a NZ context. The NZ Ministry of Health (MoH), Mental Health Commission (MHC) and Mental Health Foundation (MHF) websites, were primary sites to source government documents, crisis reviews and practice issues and provided a link to international websites and literature concerning crisis intervention service delivery. Government documents were read then chosen for their relevance to community mental health crisis service provision, regulatory guidelines and workforce development for practice. In line with the analytical framework of discourse analysis, I re-read the documents mindful of how public text such as policy and guidelines privileges certain concepts in a way that orders them as usable and understandable, whilst simultaneously constraining the production and understanding of knowledge that might offer an alternative view (Ballinger & Cheek, 2006).

Since the implementation of the MHA (1992) and development of crisis services during the 1990s, mental health service configuration has changed, as has the workforce and the policy, guidelines and auditing process of such has vastly developed. Despite this, inpatient services continue to be stretched to capacity and community mental health teams have waiting lists, as do supported accommodation providers (MoH, 2013b; O'Brien, Thom & Hughes, 2007). There appears to be no less need for crisis teams to use the MHA (1992), admission of service users to inpatient services has not reduced and the cost of government funded mental health care has not stabilised (MoH, 2013b; Oakley Browne, Wells, & Scott, 2006). In 2011, the Mental Health Foundation (MHF) reported a concerning trend of increased need for assessment and implementation of compulsory care stating that:

> In 1954, 87.9 per 100,000 people were subject to compulsory interventions per month in New Zealand. By 1969 the rate had dropped to 70.1 per

100,000. Between 1969 and 1992 the numbers continued to decline. However, between 2005 and 2010 the rate rose to near 1954 levels (2011, p.2).

Despite the information outlined in the MHF (2011) report, established nursing, medical and government funded doctrine concerning crisis services is mostly void of explanation or discussion regarding increased use of compulsory interventions.

Mental health discussion and policy documents suggests that there are clear roles and responsibilities for crisis services to provide timely, accessible (MoH, 2000b; MoH, 2001c; MoH, 2006a; MoH, 2012; O'Hagan, 2006) and acceptable (Evans et al., 2006; MHC, 2005a; 2012 a/b Te Pou, 2009) community based interventions (MHC, 2008a; MoH, 2008c; 2012, a/b). Yet, service users are arguing for no-force advocacy to service provision (Mind, 2011; Minkowitz, 2006; 2010; O'Hagan, 2003), families continue to voice a lack of support for their role as caregivers to family members in crisis (Goldsack, Reet, Lapsley & Gingell, 2005; Lakeman, 2008; Mental Health Council of Australia, 2012; MHC, 2010) and there is ongoing attention from the media about inadequate resources and responses to people experiencing mental health problems and the perceived danger that they present to themselves and others (Barnett & Barnes, 2010). Published NZ service user (Gordon, 2006; Gordon & Ellis, 2013) and family research (Barnett & Barnes, 2010; Dimmendaal & Watson, 2005) which highlights deficits in the mental health system along with my own clinical practice raises questions as to what is being said in mental health policy and grey literature. With these perceptions and my own expectations I developed this project in order to question the status quo and sought out a means to develop a critical inquiry into crisis intervention.

1.3   Investigating the field of crisis intervention in New Zealand

During an initial literature review a scarcity of qualitative perspectives of crisis intervention was identified. In contrast, a significant amount of quantitative studies publishing the results of crisis outcome measurements, screening tools, risk assessment frameworks and the comparison of home-based crisis intervention versus standard care were readily available. I reviewed each of the quantitative and qualitative publications, which, concluded that crisis intervention remains a necessity for anyone with a serious mental illness experiencing an acute episode.

The quantitative literature readily suggested positive outcomes and support of biopsychosocial interventions when a home-based model of crisis intervention is used effectively. Positive outcomes included a likelihood that more service users continue with treatment (Thornicroft & Tansella, 2010) families reported reduced carer burden (Hoult, Rosen & Reynolds, 1984; Lumb, 2007; Petersen, 2005) and that the overall cost for community crisis care is cheaper than hospitalization (Fenton, Hoch, Herrell, Mosher & Dixon, 2002). Quantitative studies utilised a variety of positivist methods including randomised control trials, surveys measuring quality of life and comparative studies (Joy, Adams & Rice, 2004; Lehman & Lasalvia, 2010) aiming to measure reduction in symptoms through orthodox use of psychiatric diagnosis (Hoult, Reynolds, Charbonneau-Powis & Briggs, 1983; Marshall et al., 2000; Marshall & Lockwood, 2004) and biomedical treatments such as medications (Thornicroft & Tansella, 2010).

Within many studies readily available in scientific databases and journals, various quantitative researchers argue: "it is impossible to comment on the effects of crisis intervention in a 'pure' form as data do not exist" (Joy et al, 2004, p.12). Most of the studies, for example, Johnson et al., (2005); Joy et al., (2004); Tyrer et al., (2010), also concluded that despite crisis intervention being effective, over half of people in crisis who access crisis intervention end up being admitted to hospital (MHF, 2011). Furthermore, through quantitative means, the ability to investigate the knowledge, practices and experiences of those involved in crisis intervention is limited (Glover, Arts & Babu, 2006).

The qualitative literature predominantly described the demands and challenges of caring roles amongst an array of health professional responsibilities involved in crisis work. Issues such as stigma, guilt and the isolation of mental illness for service users and families were explored. Since the 1990s, crisis intervention literature has become increasingly focused on the assessment and management of risk posed by service users. Despite an increase in studies concerning the consequences of risk management for community mental health services, the field in NZ remains mostly undeveloped.

Most qualitative papers offered a reflective analysis of how crisis intervention practice has shifted in orientation toward a prominence of risk screening and

assessment as a foundation for practice. Counter to a focus on risk management within the literature, nurses, service users and families argue that new disadvantages and exclusion from services have resulted (Barnett & Barnes, 2010; Cutcliffe & Hannigan, 2001; Edward, 2005; Gordon & Ellis, 2013; Stickley & Felton, 2006). Notwithstanding the richness of descriptive and exploratory qualitative studies, the literature suggests that more research is needed within the field of crisis intervention (Brooker, Ricketts, Bennet & Lemme, 2007; Morton, 2009; Watson & Fulambarker, 2013) particularly concerning the human complexities associated with the experience of mental health crisis (Vassilev & Pilgrim, 2007) and how those who provide interventions can be of support in recovery (Morton, 2010; Vassilev & Pilgrim, 2007; Warelow & Edward, 2007).

Literature from a NZ perspective was also reviewed. There have been three national reports reviewing crisis services since their implementation in the 1990s. A report by Judge Mason (1996), titled *Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services,* resulted from a series of complaints concerning acute mental health services. Mason stated that the provision of crisis and community mental health care was problematic and inadequate. In particular, the Mason report directed new state funding toward acute community mental health services and a key new government directive to establish the Mental Health Commission (MHC) in 1996.

In 2001, the Mental Health Commission (MHC) undertook a review of crisis mental health services. The review, entitled *Open all hours: A review of crisis care in New Zealand,* outlined many issues pertaining to provision and delivery of crisis services and found that organisations play a critical role but also highlighted their significant shortcomings (MHC, 2001). Various shortcomings included a lack of access to services, problematic follow up processes and poor communication with family and significant others supporting those in crisis.

In 2006, then MHC Commissioner Mary O'Hagan published a report titled *The Acute Crisis* focused on acute mental health care and the provision of crisis mental health teams (O'Hagan, 2006). What is clear from O'Hagan's report is an aim to reform crisis services. Reforms include transformation of restrictive and disempowering processes and practice to provide accessible, acceptable services by

recovery orientated organisations. Since the reports were published there has been minimal research with people involved in NZ mental health crisis intervention. In 2008, Dury and Munro, authored a discussion article on crisis engagement from a NZ Māori perspective. They concluded that Māori have unique challenges in accessing acute mental health care, citing complex causes pertaining to health inequality and the uneven distribution of determinants of health, for example, finance, housing and education.

Whilst not specifically concerning crisis care, Mason Durie (2001) as a long standing leader of Māori mental health research and practice has voiced the aim to improve Māori health in the mental health, general health and disability sectors in order to overcome discrimination and reduce health inequalities for Māori. *He Korowai Oranga*, The Māori Health Strategy, sets the direction for the health and disability sector in relation to Māori in Aotearoa NZ (MoH, 2002). The Medical Council of NZ also provides guidance to medical professionals working with Māori within public and private mental health practice (Medical Council of NZ, 2006), as does the NZ College of Mental Health Nurses with the *Mental Health Nursing Standards of Practice* (NZCMHN, 2012).

On an annual basis the Director of Mental Health (DMH) accountable to the NZ government, publishes an annual report regarding the state of legal issues and policy impact regarding compulsory mental health assessment and treatment. Whilst the information in the DMH report does not focus specifically on crisis services, it does provide points of discussion and instruction to those undertaking statutory roles under the MHA (1992). The DMH report outlines the strategic environment of mental health services, reports on activities involved in crisis care such as reportable deaths, applications for compulsory assessment, effective interventions, reviews of legislation and statistics concerning relapse prevention plans. Statistics regarding the gender and ethnicity of service users assessed under the MHA, applications to the mental health tribunal where service users and families dispute use of the MHA and incidents concerning suicide attempts are also reported, among other figures relating to inpatient mental health care (MoH, 2008c).

Each study or report that I reviewed suggested there are gaps pertaining to how particular sorts of individuals, organisational structures and systems are

legitimised and strengthened through the operation of services. Except for the NZ reviews by Judge Mason and the Ministry of Health, no studies explored the multiple perspectives of service users, families and nurses involved in the front line access of crisis intervention or considered how the interface between the crisis service and the police is practiced. I concluded that a different type of research was required in a NZ context and developed a study designed to explore the elements of social life interconnected with other elements of mental health crisis intervention services, the *discourses* involved.

1.4 Working out a way to explore the discourses involved in mental health crisis

The epistemological position taken in this research project concerns the need to address that during a mental health crisis we become constituted as subjects of specific forms of knowledge and as a result become acted upon in particular regulated ways by others. People experiencing distress, their families and those others who may be present in the occurrence have different perspectives on the needs involved. The technologies and practices utilised by those present in the experience are privileged through law, medicine, nursing and policy. My goal in this project was to develop ideas and make a case that can create future possibilities for improved crisis care. The aim of this goal is to offer a different perspective through utilising a research method that problematises and questions the status quo in crisis intervention services.

Crowe (2005) and Roberts (2012) argue that epistemological concerns are met through shaping an analytical inquiry that guides the questions asked, data collection methods and the approach to the research. Manias and Street (2000) suggest that in such an analytic inquiry the relationship between the researcher and those being researched must fit with the epistemological approach. In my approach to this project I wanted to pursue a critical social method in order to address the ongoing stigma and discrimination associated with experiencing mental health problems. I was also interested to create an inquiry that explored the ways in which people constitute themselves as moral agents (Allan, 2012; Holmes, 2002), in that the experience of mental illness and mental health nursing presents those involved with

moral and political concerns (Cutcliffe & Happell, 2009; Perron, 2013; Rudge, Perron & Holmes, 2001).

Whist developing this study I reviewed literature concerning the care and treatment of people with mental illness. Crowe (2005) states: "The limitations of traditional positivist approaches to nursing research have long been discussed in the nursing literature" (p. 56). Crowe herself critiqued traditional qualitative approaches and suggested:

> that the assumptions underpinning [them] reveal an ideological position which proposes that reality can be apprehended by capturing the individual's point of view (subjectivity) and that qualitative researchers can directly represent this lived experience in language (linguistic representation) (2005, p.56).

From a mental health nursing perspective, the interpersonal relationship posited as the crucial component of therapeutic care for people experiencing mental illness is widely reinforced (Barker, 1999; Horsfall & Stuhlmiller, 2000; O'Brien, 1999; Peplau, 1952; Freshwater, 2012; Stevenson & Cutcliffe, 2006).

Qualitative literature concerning care of those experiencing an acute crisis was framed within a variety of methodological approaches. The predominant methods used in qualitative research were narrative approaches (Lapsley, Nikora & Black, 2002), grounded theory (Ball, Links, Strike & Boydell, 2005; Cutcliffe, Stevenson, Jackson & Smith, 2006) and *lived experience* studies using phenomenology, content mapping and a variety of semi-structured interviewing techniques with content or thematic analysis (Edward, 2005; Lakeman, 2008; O'Hagan, 2006).

In my reading of the broad qualitative studies concerning mental health care I came across a distinctly different type of literature written by nurses and other mental health professionals from a postmodern and poststructuralist approach. The similiarities and contrasts of these approaches to research are discussed in depth in chapter two and include my decision to utilise Foucault's concept of poststructural *discursive power.* My introduction to and reading of these theoretical positions persuaded me that research concerning mental health care from such a perspective opened up new possibilities to consider. These studies introduced me to a way in which I began to re-think the productivity of power within human engagement amongst those experiencing mental health problems.

In my experience as a mental health nurse, people and their families in crisis often say their perspective and voice was silenced in the encounter with mental health services. What does speak loudly in crisis care is the voices of concerned others such as the public, the media, the legal system, clinical notes, the actions of nurses and psychiatrists and the rhetoric of mental health policy and institutions. This was confirmed in my reading of the literature that consistently highlighted the progress made by new advances in medicine, psychology and nursing practice. The crisis literature readily identified what can be *done* to whom, by whom and in whose best interest such actions take place. The progress of professional status through production of expert knowledge within crisis care has come at the expense of marginalising those being acted upon and results in further silencing of service user and family views.

The disciplinary and institutional factors that influence and shape the experiences of those involved in crisis services also constrain the voicing of diversity and complexity. Hui and Stickley support this by arguing, that:

> Greater awareness is needed of the significance of language, of how subtle influences may be drawn from the rhetorical language of polices, of how these might affect the involvement of service users, and of the implications for the role of mental health nurses (2007, p.416).

Hui and Stickley's discussion of Foucault's conceptualisation of power highlights the need to consider the implications of how policy effects and is affected by people who use services. By reading nursing literature, which utilises Foucault's conceptualisation of power, my thinking developed and it helped me to recognise that more than the subjective perspective or voice of service users and families was needed.

I was convinced that if this study was to offer something different to develop mental health crisis care I had to move beyond a humanistic position on subjectivity. Foucault states:

> Humanism exhausts itself in an endless back and forth…humanism involves a claim that man exists at the centre of the universe in a finite being who can reason within limits, which he cannot go beyond (1970, p.312).

What I mean by movement beyond a humanistic position of subjectivity is that nothing is absolute, no one great truth exists, nor is any one grand narrative of how to

explain society to be believed (Rose, 1999). Poststructuralist research informed by the theories from Foucault is about being open to change and can therefore be falsifiable (Foucault, 1982). My decision was made to examine how power and the people involved constitute themselves as subjects, acting upon others and acted upon, in particular regulated ways by others (Foucault, 1980a). In this study I became concerned with how the people involved in mental health crisis seize or become seized by subject positions within the psychiatric, psychological, nursing and public discourses.

I read widely on philosophical positions that recognise the conflict that exists within and between professional groups such as mental health nursing, psychiatry, psychology, and those that access interventions from these groups. My developing philosophical position highlighted the need to question how the operation of knowledge and power can be employed in a way to generate and maintain certain subject positions. Critical mental health nursing literature guided me to the theories of Michel Foucault and a methodology of discourse analysis.

Foucault's innovative methodological approach is to *historicise* and to *politicise* the knowledge involved in human sciences (Rabinow, 1984, p.4). The methodology of discourse analysis is a research method that includes a variety of ideas and approaches within the human social sciences (Fejes & Nicoll, 2008). Discourses are what Foucault referred to as *bodies of knowledge*. Psychiatric, psychological and nursing bodies of knowledge are "historical manifestations of a whole range of institutions, economic requirements, and political issues of social regulation…" (Foucault, 1991a, p. 51).

Crowe (2005) argues that discourse analysis incorporates how a person's experience is socially and historically constructed through language, which is an ontological shift in the traditional approach to qualitative methodology. The ontological shift is noted by Crowe because: "It places the social and historical context, rather than either the researcher's hypotheses or the individual's experience, as central to the inquiry process" (2005, p. 56). Discourse analysis utilises a theoretical position in which subjectivity, knowledge and understanding are constructed through language, meaning and practices and are, therefore, discursively constituted. Discursive practices or activities produced by discourses and discourses

per se, occur in a particular context and this is central to the research process of discourse analysis. The analytical tools of this discourse analysis are informed by the political ontology of Michel Foucault. Ideas and theoretical understanding influenced also by critical mental health researchers, are utilised throughout the discussion in order to create a foundation for the interrogation of multiple perspectives and discourses concerning mental health crisis intervention.

In this thesis I offer a critique of a mental health service within which mental health nurses play a key role. My hope is that mental health nurses and others associated with providing services for people experiencing crisis, rethink how it is that they have come to know what they know. Kelly (2009) suggests that Foucault's analysis of power promotes reconsideration of prior understanding in the reader. Foucault argued that people are capable of resisting in many different forms, and that we must. He states: "…I believe one of the tasks, one of the meanings of human existence – the source of human freedom – is never to accept anything as definitive, untouchable, obvious, or immobile" (Foucault, 1988a, p.1). The purpose of creating research that potentially provokes resistance in the reader is to create communication between the reader and the researcher's ideas, informing new knowledge in a specific setting or time.

During this project I have found myself contemplating knowledge and perspectives that I had not previously considered. Some of the ideas that I have held as a person and a mental health nurse that I thought or *knew* to be true and right, are no longer understood that way. Thus, in this thesis, I aim to explore spaces where power and resistance can occur. Furthermore, through a critique of dominant discourses, my goal is to open up the networks of power and knowledge that support and legitimise them, to make way for resistant discourses that speak about crisis intervention in alternative ways (Ballinger & Cheek, 2006).

1.5   Problematising mental health crisis intervention

The majority of literature available concerning the practice of crisis intervention is quantitative research. Studies of crisis intervention are underpinned by research stemming from psychological and medical perspectives of how a person experiencing symptoms of mental illness becomes a social crisis. The basis of this understanding is a biomedical discourse. As a result the person experiencing a

mental health crisis is seen to be exhibiting signs and symptoms of biological and psychological pathology. Such a perspective has implications for the subject positions constituted upon people in crisis and this affects the perceptions and actions of others involved, including family and friends, health professionals and the public in general. The experience of a mental health crisis is unique. In this thesis I aim to question the development of scientific evidence such as medicine that is considered true and factual. Medicine and psychology focus particularly on inference, probability and cause and effect, all of which have formed a matrix of disciplinary knowledge in the mental health setting and beyond (Cox Dzurec, 2003; Hoult, 1986; Marshall & Lockwood, 2004). Disciplinary knowledges are put forward in mental health care as empirical, scientifically advanced and argued to be valid and more valuable than alternative interpretations of human distress.

The main function of this discourse analysis studying mental health crisis, is to highlight the historically contingent and socially constructed character of professional forms of knowledge and practice. A key purpose of critically examining discourses is to consider how the people involved influence subject positions. The intention is to explicate divergence and power at play that subsist within the discursive field of crisis intervention. Discursive fields are the totality of all effective statements written or spoken, which encompass every form of practice that systematically forms the objects of which it speaks (Foucault, 1972). Discursive research highlights the discursive resources drawn on to conceptualise mental distress. Alongside this is a goal to foreground discourses that may be subjugated, silenced or positioned as the *other* (Jensen, 2011). A discursive field of crisis intervention is considered through the production of texts from a variety of sources.

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 (1994) discourse encompasses ways of acting and explaining action in society. Foucault played a central role in the development of discourse analysis and some suggest all discourse analysis approaches have their roots in his ideas (Phillips & Jorgensen, 2002; Seibold, 2006). Foucault's discourse theory views knowledge as all kinds of contents which make up consciousness or kinds of meaning used by historical persons to interpret and shape the surrounding reality. He suggests that people gain knowledge from the respective

discursive context into which they are born and in which they are involved throughout their lives.

Foucault's emphasis to question what was being said within what was said suggests a paradox in that individuals must then have their own unique discourse to be able to balance and judge against that of another (Hui & Stickley, 2007). This may produce differences of opinion or close agreement, the development of polemic discourses (Foucault, 1991b). By examining polemic discourse a potential for differing knowledge and meaning involving language, relationships, associations and disassociations within the construction of mental health crisis intervention can be developed.

In this study text has been generated for analysis from interviews with people and published literature relevant to the intentions and implementation of mental health crisis intervention. Nine of the texts are from interviews with adults who experienced a mental health crisis, eight are from families who have supported someone significant in their life through a mental health crisis, nine are interviews with mental health nurses who work in crisis intervention services and two are with senior members of the NZ police force. Analysis of textual material forms the basis of this research project.

1.5.1   Research question

What are the converging and competing discourses, strategies and technologies involved in the field of mental health crisis intervention?

1.5.2   Aims of the study

The aim of this research is to explore the field of mental health crisis intervention within a NZ context with a goal to challenge current practices. In line with a poststructural research project I developed the aim in three ways:

- 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 crisis services could utilise to engage people and their families/significant others experiencing mental health crisis

1.6   How the thesis is structured

In accordance with Foucault (1972) a historical ontology of truth focuses on how particular objects come to exist in a particular system of knowledge.   An ontology or discourse of truth, has the aim to uncover the rules by which objects contrast and are placed into sequence in order to form a particular field of knowledge. Objects, according to Foucault are not waiting, complete and exterior to discourse, to be discovered by a discipline that was destined to know them. Rather, discourses "systematically form the objects of which they speak" (1972, p. 49).   In regard to crisis intervention, this domain of ontology leads to the recognition that we are not dealing with an essential pathology whose nature resides outside of discourse awaiting its discovery by psychiatric or nursing knowledge.   An experience of a mental health crisis is not a condition about which we can unproblematically amass absolute knowledge; more exactly, it is a discursively constituted object.

The critical domain of ethics, according to Foucault (1997b), examines the modes operating that cause individuals to exercise action upon themselves. Asserting that forces of power and subjectification do not passively position people, Foucault argues to the contrary that people relate to themselves in an active fashion. A domain of ethics questions the ways in which people form and recognise themselves as certain types of subjects.   This includes how people represent meaning and value to their conduct in line with certain ideas and how they conduct themselves accordingly.

This suggests that the individual does not invent how one governs one's own actions per se; instead, actions are formed by cultural modes that offer rules, advice and opinions on how one should conduct oneself appropriately (Foucault, 1988a). The domain of ethics has particular relevance when considering the experiences of people in crisis. In his concern to allow us to examine the ways in which people are incited to constitute themselves with rights, needs, responsibilities and so forth, Foucault's concern with ethics allows examination of these responses.

This thesis is structured with three domains in which to engage in a *critical ontology of ourselves*. Foucault, in his later writing, stated:

> The critical ontology of ourselves has to be considered not, certainly, as a theory, a doctrine, nor even a permanent body of knowledge that is accumulating; it has be considered an attitude, an ethos, a philosophical critique of what we are is at one and the same time the historical limits that are imposed on us and an experiment with the possibility of going beyond them (1984, p.50).

Chapters one to four are situated in the domain of truth through which we become constituted as subjects of specific forms of knowledge. Chapter five and six are concerned with the domain of power in which we are constituted as subjects acting upon others and acted upon in particular regulated ways by others. Chapter seven and eight provide discussion concerning the domain of ethics, "through which we constitute ourselves as moral agents" (Foucault, 1997a, p. 262).

Following this introduction I have chosen to present the thesis in a way that positions the methodology and methods chapters before presenting a literary history on crisis intervention. In doing so, I am able to introduce the philosophical and theoretical ideas of postmodernism, poststructuralist, works from Foucault and discourse analysis. Thus, various concepts and language underpinning the philosophical and theoretical ideas can then be drawn on to critically question the literature and frame data analysis involving crisis intervention in this study.

This chapter began with the background information, which situates my role as a researcher investigating the discourses involved in mental health crisis intervention. Next I described the influences of philosophical and theoretical perspectives from Foucault on my thinking and how they frame the research question, aims and structure of this critical ontology of crisis intervention.

In the second chapter I outline the chosen theoretical perspectives underpinning this study, the relevance of postmodernism/poststructuralism and discourse analysis within the interpretive paradigm, including its goal of political action, agendas and values up front. The assumptions are outlined in regard to a process of social and health related research; this includes discussion on what constitutes the genealogical approach used in this study. Then in detail, I discuss theoretical ideas from the work of Michel Foucault, which I have utilised to inform

and shape discussion about the discursive field of crisis intervention in this study. Following the discussion concerning Foucault's methodological principles, I outline the selection of other key informants in regard to theoretical ideas used to shape the methodology and inform the data analysis.

In chapter three an overview of discourse analysis, participant selection and the process to engage them within interviews, ethical issues and discussion on reflexivity utilised in this research is presented. Chapter four is the beginning of an archaeological and genealogical analysis concerning literature within field of crisis intervention. Here I discuss the key concepts being explored within this study within a historical literary review.

Rhetoric of holistic nursing in a crisis is the first participant data driven discussion on the practices of crisis intervention. This includes issues of assessment, diagnosis and outcome measurement tools underpinned by mental health legislation and policy. I argue that whilst risk management and the therapeutic relationship form an important part of the disciplinary regime in mental health nursing, the exercising of policing and pastoral care through fear and threat has had an unintentionally disciplining impact. The discursive practice of being labeled *risky* results in divergence in mental health law and policy.

All fear and no care is the second data driven chapter that explores crisis as an event in the lives of service users and families. Objectification of the participants is explored through Foucault's notion of bio-power. The analysis of data in terms of bio-power, highlights how the people involved in crisis negotiate and navigate particular dynamics of power that direct their positions as subjects and how new sets of criteria about their conduct are formed.

Framing transformative action is the title of chapter seven. Here I present further analysis of participant data and utilise Foucault's later theoretical position concerning ethical work on ourselves. Through elaborating on ethics in relation to crisis intervention, attempt is made to refute the argument that genealogical analysis of disciplinary techniques are pessimistic and portray individuals as unlikely to resist successfully.

Chapter eight is the concluding chapter of this thesis where I review and revisit the findings of this study.   In this chapter the resistances taking place in the development of crisis services are argued as an ethical project in which all concerned have responsibilities. The discussion summarises the key converging and competing discourses concerning crisis intervention in order to disrupt structural systemic inequities. I further argue that self-reflection is required in order to attend to the ways one's experiences effect and contribute to maintaining the status quo. I present the limitations of the study and put forward suggestions for future research in this discursively constructed field.

1.7   Summary

Chapter one has presented the background information, which situates my role as a mental health nurse and researcher investigating the dominating discourses involved in mental health crisis intervention. A variety of socio-political issues regarding development of crisis intervention was introduced suggesting that Aotearoa NZ crisis services involve strategic relationships of which power consists. Following this I described the influences of philosophical and theoretical ideas from Foucault and mental health research on my thinking and how they frame the research question and aims of this study.

In the next chapter I focus discussion on the epistemology and theoretical perspectives of this study. I present in detail the archaeological and genealogical principles informed by the work of Michel Foucault and outline important concepts used in this study. Throughout this thesis, highly contextual and only partial accounts of mental health crisis and interventions are offered, and I want to say again that this study in no way attempts to present a set of findings seen as able to be generalised to all persons involved in the experience of mental health crisis intervention.

What is offered in this thesis is an exploration of the elements of social life interconnected with other elements of crisis intervention. By exploring the influence of privileged and subjugated discourses involved in this discursive field, ways that service users and families are enabled in inclusive care or not can be considered, including the implications for the role of mental health nurses.

Chapter two: Theoretical perspectives and methodology

2.0   Introduction

In the previous chapter I introduced the main focus of this study that is to explore the types of knowledge and practices involved in the experience of mental health crisis intervention.   I explore how people in mental health crisis become known as such and what effect discourses have on the participants. What follows in this chapter is an overview of the philosophical perspectives I have used to view all text generated within this research project.

In this chapter I outline the chosen theoretical perspective that underpins this study and the relevance of postmodernism/poststructuralism and discourse analysis within the interpretive paradigm, including its goal of political action, agendas and values. Methodological assumptions are outlined in regard to a process of social and health related research, including what constitutes discourse analysis in this study. I discuss theoretical ideas from the work of Michel Foucault, which shapes the discursive construction of mental health crisis intervention.

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.   Through his genealogical method, Foucault challenged the humanistic construction of an individual. Foucault cautions researchers of the human sciences that the words *human* and *humanism* are not just descriptive terms, they have normative variation. Along with normative variation the terms carry with them a push/pull mechanics of ought/should statements (Davidson, 1997).

In his suggestion that there is no such fixed identity, he dispensed with the constituent subject and focused on the ways in which language is involved in the constitution of the *other*. This chapter 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. Governmentality, expressed by Foucault, concerns the ways in which the population [service users, families, nurses and the police] is made subject to regimes of so-called truth and how conduct is

regulated. Foucault's work is used throughout this thesis to explore the discourses of service users, families and mental health nurses and others related to the actions of crisis services. This chapter begins the theoretical foundations of the study, which is completed in the next method chapter on the approach to critical discourse analysis used in this research project.

2.1 Qualitative enquiry

This study is a qualitative inquiry that considers some of the knowledge and practices involved in mental health crisis intervention. Qualitative research varies considerably however there are basic tenets or commonalities that unite seemingly disparate methodologies (Hsieh & Shannon, 2005; Sandelowski & Barroso, 2003). Amongst the debate on what constitutes qualitative methodology is the nature of the social world, or ontology and how it should be studied.

Critical discourse analysis is a qualitative approach to research in the traditions of postmodernism and poststructuralism. There are a variety of ways to perform a discourse analysis but according to Cheek and Rudge (1994) all procedural variations share common goals and assumptions. Powers argues that discourse analysis "is based on several historical developments in the philosophy of science, social theory, and literary critique" (2001, p.2). Major theoretical influences on discourse analysis as a method; include anti-foundationalism, postmodernism, poststructuralism, critical social theory, feminist theory and the work of Michel Foucault (Powers, 2001). Brief discussion on theoretical influences begins this chapter.

Foucauldian discourse analysis has been suggested to be an expansive and diffuse field within qualitative research (Arribas-Ayllon & Walerdine, 2007). Many researchers are reluctant to term their research as Foucauldian, since this is somewhat counter to Foucault's founding principle of avoiding predefined methodological and intellectual work. However, for the purpose of simplifying reference to the methodological approach taken in this study that includes propositions from Foucault's archaeological and genealogical approaches, I shall use a broad term of Foucauldian discourse analysis.

In undertaking a discourse analysis informed by Foucault's ideas, a need to avoid a potential hazard of formalising an approach that eschews formalisation (Arribas-Ayllon & Walderdine, 2007) is required. In other words, there are no specific rules or procedures for conducting a Foucauldian discourse analysis however it is neither an *ad hoc* nor incomplete approach. As with all qualitative studies, researchers develop an approach that maintains a recognisable connection between the theoretical presuppositions underlying the study and the text. The following discussion introduces the theories of postmodern and poststructural epistemology through a critique of foundationalism.

2.2 Postmodern and poststructural epistemology

Theories of postmodernism and poststructuralism offer critique of modernism and suggest explanations of power and control as social processes. They both provide a challenge to the view that it is possible to "represent any aspect of reality in its entirety, speak for others, make truth claims or attain universal essential understandings" (Cheek, 1999, p.385), however, they have distinct differences. Mitchell (1996) suggests theories of postmodernism and poststructuralism are crucial to the understanding of relationships between health, culture and society. Cheek (1999) argues that as the use of a postmodern or poststructuralist approach has increased in health care research so too has the lack of clarity as to what constitutes this type of enquiry and its approach. Therefore, the following discussion begins with a critique of foundationalism, followed by the difference between postmodernism and poststructuralism and why I term this research poststructuralist.

2.21 Critique of foundationalism

The word foundationalism embodies some of the underlying assumptions of the empirical traditions of scientific investigation. Foundationalism is discussed here with the purpose of demonstrating that the methodology of discourse analysis is anti-foundational. The natural sciences are the most commonly cited examples of the empirical tradition and labeled in contemporary philosophical writing as foundationalism (Powers, 2001). Physics, chemistry and biology are examples of natural sciences that were originally designed to be methods aimed at the technical exploitation and control of natural phenomena (Habermas, 1971; Held, 1980). Habermas (1971) argued that people have become the subjects and objects of these

control phenomena despite their original design being for the exploration of nature. Critique by critical social theorists suggest ideologies such as science and technology have, and continue to, produce a heightened level of technical control over nature and people in the name of assumed value-free goals such as predictability and efficiency (Fairclough, 2007). Social theory critique challenges the foundational ideas of tradition of science and its philosophical underpinnings of logical positivism.

Logical positivism has four key assumptions, which are crucial to understanding a critique of foundationalism by critical social theorist and approaches used in a discourse analysis (Agger, 1991; Cheek, 2004). Held (1980) suggests the first assumption is the existence of a foundation of facts available to people in an objectively real world through sense perception. Second is an assumption that a direct correspondence exists between our sense perceptions and these absolutely true facts. Third, that fact and value are separate notions independent of each other, so empirical science can only deal with facts without dealing with values at the same time. Lastly, the process of empirical science deals only with true facts of a situation and can therefore discern the philosophical essence of a concept and its relationships, such as the causal relationship.

One result of these foundational assumptions is claims of value-free empirical knowledge commonly known as the scientific method (Powers, 2001). Other research traditions that do not base a claim on this value-free perspective according to logical positivism can be rejected as irrational or not legitimate. Therefore, such a theoretical perspective would infer that philosophy and ethics have no basis to critique scientific claims because these disciplines unlike science admit value judgments (von Dahlern, 2013).

Logical positivism underpinned modernity, and is associated with western societies and began in the eighteenth century during social, economic and political upheaval (Smith, 1996). During this *age of enlightenment* there was "increased secularisation of societies and a growing dominance of philosophical and scientific rationalism" (Mitchell, 1996, p.201). Seidman and Wagner (1992) suggest the basic assumption of modernity is that human order is essentially governed by general principles that can be illuminated by scientific analysis. Furthermore scientific

knowledge based on empiricist epistemology is believed to be the means by which *true knowledge* could be found. Modernism associated with humanism, takes the human experience as the starting point for man's knowledge of himself [sic] (Mitchell, 1996). Next is an overview of the social movements of postmodernism and poststructuralism.

2.22   Postmodernism and Poststructuralism

In the search for a definition or a description of postmodernism many problems are encountered. At the centre of postmodernism is resistance to any form of identification as Garvy (1998, p.119) suggests: "such practices present an attempt to pin down an essence which does not exist". Best and Kellner (1991) indicate, "one is struck by the diversities between theories often lumped together as *postmodern* and the plurality, often conflictual, of postmodern positions" (p.2). Postmodernism and the introduction of it require discussion of what is clearly meant in this research to be a postmodern and the theoretical extension to critiquing modernity that is termed poststructuralism.

Postmodernist approaches are a collection of theories, each with their own emphases and applications of postmodern thought. Reed described postmodernism as "a social movement and philosophy that originated among French literary theorists in the 1960s" (1995, p.71). Although postmodern ideas were expressed before this time the movement as such is considered a rebellion against the theoretical principles and assumptions of modernity (Doll, 1993). According to Cox-Dzurec (2003) a postmodern approach addresses "not points of truth, not falsity of truth claims, nor issues of validity or accuracy" (p.64). Instead, postmodernist analysis historicises a phenomenon within social life to examine what about it could have evolved, given the current political, social, scientific context or the background of political relations of power against which claims of *truth* have developed (Cox-Dzurec, 2003). Furthermore, Cheek suggests "it is useful to look for similarities in approaches labeled postmodern…when this task is undertaken, it emerges that all approaches considered to be postmodern question the assumptions embedded within modernist thought" (1999, p.384).

Poststructuralism is a movement in philosophy, which developed significantly within the 1960s. Influence can be seen not only in philosophy but also

in politics, literature, history, art, sociology and cultural studies. According to Williams (2005), the influence of poststructuralism is controversial because it is often seen as a "dissenting position" (p.1) or a position, which is rebellious with respect to the sciences and to established moral values. Poststructuralist approaches in research are doubtful of the rational certainty and tidy logic of empiricism, the dominance of the author in hermeneutics and the totalising within historiography. This doubt about such theoretical approaches was also criticised by Foucault in his suggestion that they ignored the material implications of power and knowledge.

Poststructuralism, according to Crotty (1998), abandoned positivism. Through this methodological approach the meaning of language, culture and social relations is to emphasise the need to question, "what is being said in what was said" (Foucault, 1979a, p.31). This suggests language is situated within societal relationships of power and poststructuralist researchers "call upon the reader to be an active creator of meaning" (Crotty, 1998, p.204). According to Butler (1990) poststructuralists consider that power pervades the very conceptual apparatus that seeks to negotiate its terms, including the subject positions of the critic. Poststructuralists criticise the ways that power authorises knowledge and forms identity to make possible a certain form of politics focused on opening up new possibilities. Therefore, whilst postmodernism suggests that the way reality works has fundamentally changed in recent years; poststructuralism suggests reality has always been made to work through complicated articulations of modes of understanding and relations of power, which in turn produce a variety of outcomes (Agger, 1991).

In the following discussion I suggest how a postructural enquiry utilising Foucault's theories can be mobilised to critique current practice in mental health crisis intervention by treating knowledge as local contingent, specific and historical. The use of selected ideas from Foucault in the study is to incorporate them to develop useful theory, which can contribute to social equity for service users and families involved accessing crisis services.

2.3   Perspectives from Foucault used in this project

Michel Foucault (1926-1984) a French philosopher challenged the ontological, epistemological and methodological assumptions of modernism

(Dreyfus & Rabinow, 1982; Fairclough, 2007; Tremain, 2012). His analysis of relationships concerning human experiences such as illness, madness and sexuality; knowledge within the human sciences and power have been utilised by health care researchers (Cheek & Porter, 1997; Hamilton & Manias, 2008; Winch, 2005) and in particular, mental health researchers in recent years (Cutcliffe & Happell, 2009; Flaming, 2006; Holmes & Gustaldo, 2002; Perron, Rudge, Blais & Holmes, 2011; Perron, Rudge & Holmes, 2010).

In *The Birth of the Clinic*, published in 1975, Foucault traced an emergence of insanity becoming a psychopathology of the human mind/body and a shift to the anatomo-clinical gaze. He argued that by medicine incorporating psychopathology into the discipline, a reinterpretation of pathology as an observable and quantifiable variation of what was considered normal occurred in history (Foucault, 1975). In chapter four I discuss a literary history pertaining to the historical and contemporary context of crisis intervention and draw on specific works for their relevance to madness and social control. Strozier (2002) suggests that Foucault was not a critical theorist in the sense that he did not develop a theory explaining cultural formations. However, through genealogical enquiry his interest in how new events could emerge at specific historical points and critique of how these events could be interpreted as natural or inevitable, has been developed by many poststucturalist researchers (Paras, 2006).

2.31 *Discourse and power*

Various authors suggest Foucault's work covered three identifiable periods (Cheek & Porter; 1997; Henderson, 1994; Taylor, 1984). In his original writings termed the archaeological period (McNay, 1994), Foucault focused on the analysis of the relationship of knowledge and power through discourse. The concept of ideology or similar symbolic or non-material definitions of power were criticised by Foucault who rejected them because they necessarily imply a pre-existent truth situated elsewhere (Foucault, 1975; 1979). Instead he argued the production of knowledge is inescapably bound up with historically specific regimes of power. Furthermore, every society produces it own truths that have a normalising and regulatory function (Foucault, 1984b). In place of the concept of ideology, Foucault substitutes the notion of discourse.

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 (1980b) 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, the biomedical discourse provides possible ways to understand bodies, patients, doctors and nurses (Rudge & Holmes, 2010).

Another discourse is that of personal recovery (Barnes & Shardlow, 1997; Pilgrim 2008). Personal recovery discourses seek to explain experiences of self-determination of mental health service users (Deegan, 2005), right to social inclusion (Pilgrim, 2005) and citizenship (Mental Health Advocacy Coalition, 2008). Self determination, social inclusion and citizenship are impacted as a result of the experience of mental distress.

In his early work, Foucault focused on how power operated on the microphysical operational level in institutions such as hospitals, prisons and schools. From this period his notion of discourse and power was developed. Foucault (1988) envisaged power not to be a reality lying there for its meaning to be discovered. Rather, power is a generator of reality and meaning. Power is not a thing that is held and used by individuals and groups it is both a complex flow and set of relations between different groups and areas of society that changes with circumstances and times (Foucault, 1975). Power is not solely negative or working to repress or control people, it is also highly productive (Foucault, 1977).

Power produces resistance to itself, it produces what we are, what we can do and how we see ourselves in the world (Danaher, Schirato & Webb, 2000). Foucault suggests power "reaches into the very grain of individuals, touches their bodies and inserts itself into their actions, attitudes, their discourses, learning processes and everyday lives" (1980a, p.39). Thus, discourses are not the effects or end products of power; rather, power relations are seen to be engrossed in discourse (McHoul & Grace, 2002).

Weldon (2006) further suggests that people comprehend and apply discourses using their here and now everyday experiences and that it is likely that discourses are used in a taken-for-granted way. According to Moss (1998) Foucault's

methodological ideas offer the researcher a powerful means of enabling forms of critique and resistance. Therefore, Foucault's theory of power and knowledge being inextricably linked provides a theoretical basis to investigate the knowledge and practices within the field of crisis intervention.

Foucault played a central role in the development of discourse analysis and some suggest all discourse analysis approaches have their roots in his ideas (Phillips & Jorgensen, 2002; Seibold, 2006). Foucaudian analysis considers knowledge as all kinds of factors that make up understanding or meaning that shapes the surrounding reality (Rabinow, 1984). That is to say that people acquire knowledge from the respective discursive context into which they are born and in which they are involved in throughout their lives.

Foucault's emphasis to question what was being said in what was said suggests a paradox in that individuals must then have their own unique discourse to be able to balance and judge against that of another (Hui & Stickley, 2007). This may produce vast differences of opinion or close agreement, the development of polemic discourses (Foucault, 1991a). Study of polemic discourses may lead to differing knowledge and meaning being considered from the same use of a word. Thus, there is the potential to consider different relationships, associations and disassociations within crisis intervention.

2.32   *Foucault and Genealogy*

From Foucault's archaeological analysis he developed further ideas that challenge the way discourses are institutionalised and regulated. The next phase of his analytical writings, is termed the genealogical period of theory development. Genealogical analysis and the theory of governmentality will be discussed next.

Foucault's genealogical analysis aims to problematise the *will to truth* and restore discourse to its character as an event. The notion of genealogy and the character as an event signaled a shift in his ideas concerning power (McNay, 1994). Historically Foucault's notion of power changed and developed. He described the evolution of power over time and how select individuals held it originally, for example, a monarch of a nation, who displayed it in impressive or dramatic ways; to later becoming a subtle force resting on several agents (Perron, Fluet & Homes,

2005). Power shifted and permeated into social worlds by means of uniform networks or disciplines. For example: medical, nursing, legal, political, educational institutions that are positioned to exert power over everyone in society (Foucault, 1982). Foucault proposed four methodological *injunctions* (Foucault, 1984c) in regard to the potential of genealogical inquiry. The purpose of injunctions is to regulate the analysis so that the researcher might view the conditions that draw up the boundaries of discourses and create their circulation.

To begin, genealogical inquiry can assist a researcher to attend to the historical context in which their study is situated (Hook, 2007). Attending to historical context involves mapping an inquiry across a broad socio-political landscape. In this research, such a landscape involves the critical moments in the history of crisis intervention practice. Hook (2007) suggests the next injunction involves exploration of the social, historical and political conditions in which statements come to count as true or false. For example, what discourses involved in mental health crisis intervention come to be valued or alternatively dismissed? Discourse analysis focuses on the effects of particular forms of knowledge as well as key practices within the effects that knowledge contests. Thirdly, the researcher is to consider the materiality and conditions of the possibility inherent within discursive formations. Hook (2007) suggests this is a vital point as it focuses those undertaking genealogical analysis to sharpen their attention on the role played by practices and actions defining the various subjectivities under examination. Lastly, movement in and out of the text using the extra-discursive to drive the analysis of the discursive is required. Extra-discursive analysis is described by Hook (2007) as focusing on the material practices and actions that result from the forming, connection and transformation of discourses, rather than the suggestion that there is something beyond discourse. As Foucault suggested, the researcher can look carefully at the systems of relations involving discursive and non-discursive practices – the said as well as the unsaid (Foucault, 1980). Genealogical injunctions guide the analysis and separate genealogical inquiry from archaeological.

The injunctions described above serve as a beginning phase in guiding the process of a genealogical analysis, for example, systems of exclusion. Foucault (1972) proposed that systems of exclusion define what can be potentially thought, understood or stated at a particular time in history. The next process according to

Foucault involves questions of power, knowledge, discourse and subjectivity or the sets of systems mediating the role of power, knowledge and truth (Rose, 2007).

According to Hook (2007), these are termed *systems of exclusion*. The three main forms of exclusion involve internal, external and philosophical systems (Foucault, 2003). Firstly, internal systems of exclusion relate to the belief that we think up new knowledge, rather than the effect of the recirculation of previous, primary discursive constructions such as, scientific or juridical matrixes of power. Such a belief in our own originality has produced an over stating and importance of the author of newfound knowledge. Foucault refers to the author of a particular statement, discourse or text, rather than *I* – the author of this research project. In his pursuit of an alternative view of the author, Foucault proposed a reversal to the nature of questioning. Rather than asking what discursive formations does the author instill, he asked how is the author formed and transformed as a result of the actions of the discourse (Foucault, 1972). Through exploring internal systems of exclusion I will attempt to focus on the recirculation of practices of nurses and others in their roles within crisis intervention.

In comparison, external systems of exclusion include all overt efforts to ban certain ways of thinking, through restraint of ideas and ways of speaking. Binary differentiations comprise connections between reasoned and unreasoned, for example the sane and the mad, and the differentiation of what might be viewed as true or false, for example right and wrong. External systems of exclusion serve to effect mechanisms of differentiation that enable people to normalise particular ways of thinking, being and speaking, whilst marginalising certain others. Foucault (1972) argued that what comes to count as practically truthful and reasonable within a political or social system is more about the function of truth, which is constantly transforming and less about pure knowledge, or truth. Recognition of external systems of exclusion can assist the researcher to explore the places where practices of resistance might have taken, or be taking place.

The third system, Foucault (1972) termed as philosophical systems of exclusion. Philosophical systems of exclusion pertain to effects of power concealed beneath idealised notions of truth. Foucault was concerned with ways in which various forms of exclusion collude to create an idealised notion of truth within

Western society. Through collusion, philosophical systems effectively conceal the power effects of discourse, which come to occupy the least available space between thinking and speech. Therefore, power effects become imperceptible or hidden behind a collection of systems, rules, rituals and procedures and develop into taken-for-granted knowledge or practice thus implying that truth is somehow stable and absolute, further obscuring the operations of power from view (Hook, 2007).

Systems of exclusion focus on the conditions that constrain how statements construct certain subjectivities. By exposing systems through analysis, they can be problematised to see how they contribute to and form legitimated thoughts and actions possible. Moreover, by scrutinising the kinds of knowledge that are valorised or marginalised, how people have come to speak in a certain way about their own action and that of others in order to adopt or privilege a certain subject position, can be explored (Nicholls, 2009). Analysis of the systems of exclusion within mental health crisis intervention can contribute to exposing the power effects that might be concealed beneath the accumulation of disciplinary strategies, technologies and material practices.

According to Foucault (1991a) discourses are not just expressions of social practice; they serve certain ends, primarily to exercise power with all its effects. Discourses do this because they are institutionalised and regulated and because they are linked to action. The dominating discourses can be criticised and problematised through analysis, revealing their contradictions and silences of what is and could be said. By revealing contradictions, silences or the spectrum of what can be said or not, the researcher can make apparent the means of how the acceptance of temporarily valid truths is achieved (Ignaas & Van Hoyweghen, 2011). What is meant is assumed truth that is then presented as being rational, sensible and beyond all doubt. Next, further explanation of a genealogical analysis continues with a discussion on governmentality.

2.33 *Foucault and governmentality*

The concepts of social and individual control and matters that relate to it in this study will be analysed using Foucault's concept of *governmentality*. Governmentality is a web of power relations that link together three distinct forms of power: sovereignty, discipline and government (Foucault, 1991b). Foucault (1991a)

describes the transference of power to others as governmentality. For example law and policy or strategies, provide power for guidelines or technologies, to be acted upon by people in material ways. However, Lloyd (2007) argues that governmentality can also remove power from workers in the services and service users, in order to maintain the power and control over the organisation.

Danaher et al., (2000) suggest that governmentality relates to government or governing involving *body politics*. The concept of body politics involves the way in which we conduct ourselves, the relationship that we have with our body and other bodies in society and in a more conventional sense, the way in which a state rules over its people (Rose, 2007). A component of body politics is *bio-power*, which is the discourses, strategies and technologies used to bring about the management of the state's human resources. Bio-power analyses, regulates, controls, explains and defines the human subject, its body and actions (Rabinow, 1997). Within bio-power is *micro-power* a concept Foucault (1988a) described as a way that discourses write up the body, or shape them so they can be understood and function.

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). Furthermore through liberal attitude, is an understanding on the part of citizens to negotiate those regulations through the process of self-government (Barry, Osborne & Rose, 1996). As a result *subjectivity* and normativity come into question.

Subjectivity is a term Foucault coined to explain or describe identity of the self. 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 (Danaher et al, 2000). 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).

Discourses are controlled through procedures of exclusion that function via strategies of prohibition, division and rejection of a *will to truth* (Foucault, 1980b). Strategies of prohibition operate in the form of taboos on the object of speech, constraints on the circumstances of speech and the authorisation of certain speaking *subjects*, for example, the psychiatrist or the mental health nurse. Strategies of division and rejection are ways that *rational* discourses necessarily deviate or separate. Then they exclude certain discourses to form an experience of the *other*, in order to maintain the integrity of its own identity (Foucault, 1997b). The notion of *will to truth* establishes a distinction between truth and falsehood, thus determining how knowledge is put to work, maintained and distributed. For example current mental health services are justified through notions of truth constructed in political, medical and legal discourses.

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 suggested there is a need to recognise both the historical political influences upon mental health service users and the move toward health becoming less in the control of those accessing and providing services (1980b; 1984d; 1994).

Governmentality involves domination and discipline techniques as well as the ethics of self-government. Strategies, technologies and tactical aspirations of particular authorities shape beliefs and the conduct of a population (Holmes, 2002; Holmes & Gustaldo, 2002). According to Foucault the governmentalisation of the state unites different forms of power and is supported by tools of security. These tools of security translate to strategies of *police* and *pastoral power* (Holmes, 2002). The concepts of police and pastoral care, a function of social control, order and prevention are used in the analysis of personal and social text. Next I discuss governmentality within the third developmental period of Foucault's work

concerning the domain of ethics. This final period of his theoretical contributions ended with his untimely death in 1984.

2.34   *Foucault and ethics*

In the final period of his work Foucault extended the discussion of power in relation to ethics. He developed from the domain of power, in which we are constituted as subjects acting upon others and acted upon in particular regulated ways by others, to the domain of ethics through which we constitute ourselves as moral agents.   Foucault described ethics as "the kind of relationship you ought to have with yourself…and which determines how the individual is supposed to constitute himself as a moral subject of his own actions" (Foucault, cited in Rabinow, 1997, p.340-372).   In this study, I examine how people experiencing crisis and those who work alongside or on behalf of them govern themselves, rather than the importance of a particular moral code. Thus, moral action is about a relationship with the material context in which the self is constructed.

In his later writing about ethics and self, Foucault moved to an analysis of "interiority of the subject" (Dean, 1994, p.32). Analysis of the self is still viewed as a historical and cultural phenomenon created through discourses, strategies and technologies, but now includes a field marked out by a culture involving care of the self.   Therefore, how one fashions their actions and their ability to care for themselves in accordance with certain requirements involves a form of *agency* (Winch, 2005).

Agency according to Foucault (1991a) does not imply a rational, unified or autonomous self. Rather, work on the self is an autonomous act requiring the use of moral and intellectual capacities to determine a course of action (Moss, 1998). Dean (1999) suggests that when analysis of data is framed within governmentality, the notion of "conduct of conduct" must incorporate the idea of mentalities and the associations related to the concept. What he is suggesting is that an attitude toward something is usually understood from within its own perspective and that the way people understand such mentalities are part of a collective contributing to the culture of a society, termed interiority of the subject.   Interiority of the subject includes the ways that conduct is governed, not just by the state or those in authority, but also by others and the self. Therefore, governing and mentalities in governmentality is the

analysis of technologies of power and the rules that underpin them. Foucault set out a typology of inter-related technologies of power, including technologies of production, of norms and of the self. I predominantly use the technologies of the norms and of the self, to analyse the practices of those involved in crisis intervention. Before I explain technologies of the self further the particular rules relating to how people govern themselves through technologies of power is detailed.

Mentality of rule delineates a discursive field in which exercising of power is rationalised (Rose, 1999). Foucault (1988b) suggested that Neo-liberalism is an example of a mentality of rule. Neo-liberalism is an attempt to link a reduction in state welfare services and security systems to the ever-increasing request for subjects to become enterprising, free and autonomous. In doing so, the state then begins to govern its subjects through creating a perception in people that there is personal and collective gain through governing themselves through their own sense of freedom; rather than through intrusive state bureaucracies backed with legislation or the imposition of moral standards with an underlying religious mandate (Rose, 1999). Furthermore, through the transformation of subjects with particular duties and responsibilities into individuals, with rights and freedoms, people become *obliged to be free* rather than *free to choose* (Rose, 1999). This is a different type of *freedom*, one that modern individuals must understand and enact in their lives through choice.

Rose (1996) argued that through our freedom to choose, certain self-governing capabilities such as *autonomy* and *enterprise* are privileged to bring our own ways of conducting and evaluating ourselves into alignment with political objectives. The autonomous self is one that takes control of their own undertakings, defines goals and plans to *get ahead* through the power of self (Devisch, 2011). Thus, autonomy is one of the objectives of modern mentalities for the conduct of conduct.

Enterprise in regard to freedom designates an array of rules for the conduct of an individual's everyday life. To be enterprising is to be energetic, show initiative, have ambition, be calculating and take personal responsibility. The enterprising self makes the most of life, seeks to maximise their own human capacity and to shape life in order to become what she or he wishes to be (Briggs & Hallin, 2007). Practices such as freedom, autonomy and enterprise instill a sense of competition within

society and an idea in people that performing better than others and being more efficient gives us an advantage and a better life (Miller & Rose, 1997). These practices are a form of self-discipline, which are instilled through particular *technologies of power.*

Technologies of power according to Rose (1999, p.52): "are imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired ones". The main technology of power is the *technologies of self.* Foucault (1984c) argued that technologies of self are strategies and techniques allowing individuals to effect by their own means, a certain number of operations on their own bodies, souls, minds and lifestyle. This is so that transformation into a certain state of happiness and quality of life might occur. Technologies of the self are strategies and practices that we as individuals represent to ourselves as a particular ethical self-understanding.

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. Rose stated: "Expertise comes to be accorded a particular role in the formulation of programs of government and in the technologies that seek to give them effect" (1996, p. 156). 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" (Rose, 1996, p. 156). Analysis of expertise features in discourses discussed in the first data chapter titled: Historical rhetoric of nursing in a crisis.

Working alongside technologies of self in the matrix of technologies of power are *normalisation,* the *confession, responsibilisation* and *healthism.* Normalisation, or a technology of norms was argued by Foucault to be a way in which what is seen to be socially acceptable, scientifically healthy and personally desirable, subjects individuals to an administration of shame should they not live up to it. Rose (1999) suggests that an important aspect of normalisation is that the norm has come to be viewed in society as natural. So those who live up to it achieve

normality. However, they only do so when working on themselves, controlling impulses, monitoring their daily habits and conduct, through teaching their children to be normal and by taking the guidance of others with expertise.

Societal norms are aligned to political goals (Hansen, 2009). Through fear of shame about one's behaviour and appearance of the self, individuals are driven to self-care in the name of achieving an ethical existence and quality of life (Winch, 2005). In the second data chapter analysis of normalisation within technologies of the self is used as a frame to explore participant data. Foucault (1980a) suggests technologies of self are a set of practical reasons that are shaped by strategies within discourses. Each technology involves a type of training to shape the individual. Another technology of the self used to shape the individual is that of the *confession.* Analysis of the confession features in the third data chapter.

In his genealogy of the confession Foucault (1988b) described a series of historical events relating to sexuality. His work on sexuality was concerned with problematising how desire, pleasure and sexuality are components of the art of living or *an aesthetics of existence* and have become discourses that shape the construction of people. One assumption in Western society is that the body and its desires reveal the truth about the self. With this assumption, it suggests that if a person tells the truth about their sexuality or another *deep truth*, then the true self will become apparent to others and the individual can live an authentic life that is in touch with their true self. However, there are a variety of prohibitions about sexuality and other *self-truths* within Western society. Thus, whilst there is a strong incitation to speak the truth, this may result in people understanding themselves in terms of what is forbidden (Foucault, 1980a).

Foucault's idea of the confession was that it "involved all those procedures by which the subject is incited to produce a discourse of truth… which is capable of having effects on the subject himself" (1980a, p.216). He suggested that in Western society, truth is drawn from pleasure itself and certain confessions became constituted in scientific terms. Sexual confession is one such example where codification of speaking, speculation about causality and interpretation become the product of the medicalisation of confession. Now, power and knowledge resides in confession, not in the person speaking but in the one who is listening and

questioning. Furthermore, Foucault pointed out the movement of confessional practices from the religious world to that of medicine and then to the therapeutic technologies and discourses of current health care. Foucault's key point in regard to the confessional was that the practice of disclosing the self through the confession has been an important development of the human sciences. This has resulted in wide use and acceptance of the confession as a normalised process within a different context. Linked to the technology of norms and the confessional is the practical and productive technology of *ethical practice.*

Foucault's later conceptualisation of technologies took on a predominantly ethical form, "focusing on repertoires of individual self-conduct as managed either through broader regimes of subjectivity, or the micro-techniques of a *care of the self*" (Hook, 2011, p.216). Care of the self is a type of specialised knowledge that an individual uses through which to calculate, measure, judge and discipline her or himself (Cruikshank, 1996). It is widely argued that a lack of self-care within individuals leads to an array of societal concerns and social problems for the individual affected (Briggs & Hallin, 2007; Salmon & Hall, 2003). However, Busfield (1996) suggests that self-care is much more about self-assessment than self-respect, as the person must continuously measure, judge and discipline themselves in order to exercise agency at a personal level. Personal agency is valued through a collective notion of what is normal and acceptable within the technology of norms.

The framework of ethical practice is used to structure the discussion chapter of this thesis. The discursive formation of crisis intervention can be elaborated on through Foucault's four dimensions of *ethical practice*, which includes: *determination of ethical substance; the mode of subjectification; self-practice or ethical work;* and *the telos* (Allan, 1999). Julie Allan, a professor of education and researcher in the UK, authored a book titled: *Actively seeking inclusion* (Allan, 1999), on the situation of special needs education in mainstream schools. Allan's innovative explanation of Foucault's four dimensions of ethical practice is briefly introduced below and discussed in depth throughout this thesis. Ethical practice begins with determination of the ethical substance. This aspect involves identifying a particular part of oneself as principle material of [ones] moral conduct. Determination of ethical substance is the process of individuals deciding which aspect of the self to work on or alter (Allan, 2012).

Next is the mode of subjection. This dimension concerns the ways in which people recognise how they operate in relation to certain rules and how they find other ways of observing these rules (Foucault, 1980a). Allan (2012) suggests Foucault's illustration of fidelity or faithfulness toward others and the self is an example of how individuals re-fashion themselves in accordance with certain aesthetic criteria. Self-practice or ethical work is the next dimension. Ethical practice according to Foucault "involves what one does not only in order to bring one's conduct into compliance with a given rule, but to attempt to transform oneself into the ethical subject of one's behaviour" (1980a, p.26). This involves the relentless attempts and measures that people might go to in attempt to transform themselves (Allan, 2012). The last dimension concerns the fundamental goal that people aim to achieve through ethical work, that of the telos.

In Foucault's illustration of fidelity, there is a need for the individual to complete *practices of self-formation* in the journey toward transforming the self. The process involves a controlled and self-monitoring distribution of the subject into the world and a positive closure, not in the sense of self-absorption, but "being absorbed into the world: a losing-finding of the self" (Allan, 2012, p.284). Ethical practice is a productive technology in which people are led to believe they must work on themselves. At a micro level for service users, self-formation meets the needs of the institution so that in the environment, experts such as doctors, nurses, the police, don't have to step in and take control. Foucault suggested that people should become so accomplished in ethical practice that they engage in it without purposeful thought (Allan, 2012).

Rose (1999) suggests that when we take up the goal of ethical self-care, we permit ourselves to be governable from a distance. Another way the state governs from a distance is through the *technology of responsibilisation.* As a strategy to reduce the cost of welfare, the state uses certain techniques to lead and control individuals without any particular responsibility for them. Foucault (1984a) suggested this to be a way in which subjects become responsible for themselves through messages from government and experts that social risks such as health problems, poverty and unemployment are actually the responsibility of the individual to solve and an issue of self-care, rather than a responsibility of the state. The

technology of responsibilisation works with the *technology of healthism* as a public objective.

Healthism involves a state objective for the population to have healthy bodies and hygienic places of living (Rose, 1999). However, the objective is not achieved through discipline or threats to those who do not comply. Instead, individuals are led to believe through the knowledge of experts that quality of life and an ethical existence is achieved through self-care and freedom to choose healthy behaviours. Whilst the technology of responsiblisation might be seen as a state strategy, healthism has arisen from new social science practices such as physical training programmes, healthy eating campaigns and work/balance lifestyle coaching. Rose (1999) argues at the centre of such healthy lifestyle practices lies the self guided by a key leading expert.

Experts tell us how to conduct ourselves to achieve healthy hearts, leaner-stronger bodies, healthier relationships, better self-esteem, emotional wellbeing and longevity (Evans, 2010). Through advertising, educational institutions and social and welfare agencies the goal of health is achieved through self-motivation, self-monitoring, self-discipline and self-responsibility (Perron et al., 2005). In doing so we make the *right* choices for our health and the health of the nation and our personal goals bring us into line with political goals that cause us to be governed.

2.35   *Avoiding over-prescription*

The purpose of defining certain injunctions and concepts within Foucault's theory of governmentality, as they have developed during different periods of his writing, is to lay a foundation of what particular methodological and theoretical intentions are guiding this Foucauldian discourse analysis. I am aware that in defining certain aspects of a wide and varied body of work by Foucault, I might be seen as being over-prescriptive or deterministic at the expense of the subtle nuances and values inherent within a poststructural critical inquiry. I am just as aware that certain concepts and theoretical ideas, which Foucault developed extensively, are not discussed in this chapter. My goal is to be clear about the particular aspects of Foucault's theories that have shaped my research practice during this project about the discursive field of crisis intervention. The discussion thus far represents only one

of many possible approaches that might be taken to a discourse analysis informed by Foucault's work.

2.4   Summary

In this chapter I have outlined the theoretical perspective that underpins this study and the relevance of poststructuralist discourse analysis. The qualitative assumptions were outlined in regard to a process of research, this included discussion on what constitutes discourse analysis in this study.   I discussed theoretical ideas from the work of Michel Foucault that inform and shape discussion about the discursive construction of mental health crisis intervention in this study. The following chapter describes the steps taken in the research process. Explanation is included on the ethical procedures undertaken that culminated in the production of data and the application of Foucauldian analysis associated with discourse, subjectivity and power to both the data collection and analysis.

Chapter three: Method

3.0   Introduction

In the previous chapters I discussed the background and relevance of an investigation about mental health crisis intervention and the theoretical perspectives that underpin this inquiry. As outlined in chapter one the aims of this research are to:

- 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 crisis services could utilise to engage people and their families/significant others experiencing mental health crises

This chapter presents the empirical basis of this study, including the methods used to collect, interpret and analyse the data. I describe my decisions associated with participant selection, ethical matters, data collection and analysis and concerns of rigor. Finally, I discuss the notion of reflexivity that has impacted on the research process.

3.1   The approach in this research

Poststructuralism is concerned with societal discourse and in this study attention will be paid to the macro-analysis of public policy - the public text; and the micro-analysis of interviews - the personal text (Fairclough, 2007). The approach is grounded in poststructuralism influenced by selected theory from Foucault. Discourse is larger than language and is conveyed within a wide range of linguistic and non-linguistic resources. Parker (1992) suggests discourse comprises sets of statements bringing social objects into action. This chapter describes methods of investigation used to explore the forms of knowledge and practices that inform the participant's relationships in the crisis mental health intervention setting. Research methods including individual interviews and policy analysis were carried out to explore the perspectives and relationships of the participants and to develop approaches for understanding, education and collaboration. Published mental health literature, for example discussion documents and research informing practice, is used

as data within this study. Utilising literature in this way rather than the conventional practice of appraising literature on a given topic then presenting it as background to the study was to intentially juxtapose the discourses on mental health crisis in the literature with those produced by the text generated from interviews and policy (Neville, 2005).

The research design includes the use of discourse analysis to examine the experiences of certain members of mental health crisis services. For the purpose of this study, participants are mental health nurses, service users of mental health crisis services, families of people who have used mental health crisis services and the police. It is the intention of this study to identify any interconnected discourses, strategies and technologies that inform and influence knowledge and power in participants' experiences of mental health crisis intervention.

3.2 Selection of participants

Purposive sampling identified key participants who were able to share their experiences of mental health crisis intervention. Individual semi-structured interviews with mental health nurses working within mental health crisis services in NZ explored accounts of knowledge and power. Semi-structured interviews were undertaken with participants who identified as previous service users, and also with family members who had accessed crisis mental health services. National Human Ethics Committee (Central region) agreement was provided prior to the collection of data (discussed below).

The data collected are personal texts that represent the use of language and its implied meaning at an individual and collective level (Fairclough, 2007). At the completion of the interviews with the nurses and people with experience of the services, agreement for ethics variation was sought to include interviews of two further participants who were senior police officers. That decision and the process involved is explained later in this chapter.

3.21 Nurse participants

Locality agreement was sought from District Health Board (DHB) mental health services located within the central regional areas of the north island including Capital and Coast, Wairarapa, Taranaki, Whanganui, Midcentral, Hutt Valley and

Hawkes Bay. Mental health crisis services have a specific contract, which only DHBs undertake in NZ. I chose DHB services to recruit nurses because they are specifically contracted to provide crisis assessment and intervention services for people in acute mental health crisis. DHB mental health teams and crisis teams also have legislative and statutory requirements including the Duly Authorised Officer (DAO) role that is of interest in this study.

Although nurses make up the largest professional group within DHB crisis services, the numbers of nurses working in teams is relatively small. The team of nurses employed within the various DHBs constitutes either a combination of stand-alone services, or teams undertaking crisis intervention exclusively without the role of ongoing case management like other community mental health services. In some areas, smaller rural based crisis intervention teams include a standalone and/or integrated model, where there is a mixture of crisis work and ongoing case-management services. An invitation to participate [appendix i], along with an information sheet [appendix ii] outlining the intention of the research and the interview process was sent to mental health crisis service managers across the identified DHBs.

Each registered nurse (RN) working in the DHB crisis service was invited to participate in an interview. Thirteen nurses responded to the invitation to participate in the study and from those, I interviewed nine nurses in total. Written informed consent was obtained from each participant including permission to voice-record the interview. For inclusion in the study the nurse was required to be a NZ registered comprehensive (RCp.N) or registered psychiatric nurse (RPN) and have a role within the standalone or integrated crisis service within a central north island DHB catchment area. The decision to stop interviewing after nine participants was based on the amount of information gained through interviewing which was at saturation point at the eighth then ninth nurse participant. The semi-structured interview format is appended [appendix iii].

3.22   Service user participants

Service user in this study is defined as a person who has experienced a mental health crisis and sought advice, information or services or been required to attend compulsory assessment and/or treatment from a crisis mental health team. Locality

agreement was gained from the national office of LikeMinds NZ. I chose to advertise the study through this organisation as they have national network of service user peer support groups. LikeMinds peer support groups have members who are service users at different stages of recovery from mental illness. I advertised the study with LikeMinds groups located throughout the central North Island and gained locality agreements in those areas outlined previously.

An invitation to participate [appendix iv], along with an information sheet [appendix v] outlining the intention of the research and the interview process was sent to the co-coordinator of the service user organisation holding the contract for LikeMinds education and peer support. I spoke at several central north island service user organisations about the research and individuals then contacted me expressing an interest to be a participant in the study. Written informed consent was obtained from each participant including permission to voice-record the interview. The semi-structured interview used in this study questions are in [appendix vi].

3.23   Family participants

Family in this study is defined as key significant others who support or have supported a person who is currently or in the past experienced a mental health crisis and sought advice, information or services from crisis mental health services. Locality agreement was gained from the national office of Schizophrenia Fellowship (SF) NZ. I advertised at this organisation as they have a national network of family peer support groups and obtained locality agreement in the geographical areas outlined previously.

An invitation to participate [appendix vii], along with an information sheet [appendix viii] that outlined the intention of the research and the interview process was sent to the co-coordinator of the SF organisation. I spoke at several central north island SF organisations about the research and individuals then contacted me expressing an interest to be a participant in the study. Written informed consent was obtained from each participant including permission to voice-record the interview. The semi-structured interview questions are in [appendix ix].

3.4   Selection of policy and documents informing mental health nursing practice

Crisis services have evolved significantly since the 1980s following the introduction of the *Mental Health (Compulsory Assessment and Treatment) Act* (1992) and substantial critique of mental health service provision in a government inquiry in 1995. The Mason Inquiry (Mason, 1996) was the sixty-seventh inquiry into mental health services in NZ and was suggested to be "a sharply focused inquiry into the availability and delivery of mental health services in New Zealand" (Mason, 1996, p.1). Analysis began with the MHA (1992), the *Mason Inquiry* (Mason, 1996) and pertinent key documents: '*Looking forward' and 'Moving Forward'* (MoH, 1994; 1997) which led to the formation of the Mental Health Commission in 1996 and publication of *The Blueprint* (MHC, 1998). Subsequent documents, which inform mental health policy, included a focus on acute crisis care; in particular *Open all hours* (MHC, 2001) and *The acute crisis* (O'Hagan, 2006).

There are several key policy strategies broadly termed as *grey literature*, intended to address the mental health needs of the population in NZ. The World Health Organisation outlines global health targets to address the needs of individuals in society (www.who.int). Global strategies informed by local needs are translated and interpreted at a national level through documents such as: *Te Tahuhu: improving mental health 2005-2015* (MoH, 2005), *The New Zealand suicide prevention action plan 2013-2016* (MoH, 2013a) and *Te Kokiri: the mental health and addiction action plan 2006-2015* (MoH, 2006a) and most recently, *Blueprint II* (MHC, 2012a; 2012b) and *Te Whare o Tiki: Co-existing problems and skills framework* (MoH, 2013c).

Alongside these policy strategies are key documents outlining the expected competence of mental health nurses and other professional groups employed within crisis services. Such documents include: *Lets get real: Real skills for people working in mental health and addiction* (MoH, 2008b), *Assessment and management of risk to others: Guidelines and development of training toolkit* (MHWDP, 2006); *Guidelines for the implementation of the Mental Health (Compulsory assessment and Treatment) Act 1992* (MoH, 2000b); *Guidelines for the role and function of Duly Authorised Officers under the MHA* (MoH, 2000b; 2012); and *The national guidelines for the professional supervision of mental health and addiction nurses*

(MoH, 2009a). Detailed analyses of these public documents are discussed in different chapters where they relate to particular discourses. These public texts were anticipated to illustrate the wider use of language and the socio-political context of meaning (Woods, 2007).

An aim of a Foucauldian policy analysis is to question what is being said in what was said (Foucault, 1991a). Analysis involves reading and re-reading of the text and highlighting sections of text that appear to be contradictory, alluding, repetitive or metaphoric (Neville, 2005). Association and dissociations of social and material practices are drawn out of the texts for discussion. The *grey literature*, for example, mental health policy documents such as *The New Zealand suicide prevention action plan 2013-2016* (MoH, 2013a), and discussion documents informing policy and clinical guidelines, for example, *Blueprint II* (MHCa, 2012) in this study is regarded as bodies of text, language, vocabulary and themes. They were examined as Parker (1992) suggests for connotations, allusions and implications and their interplay was explored in regards to their relations to broader systems of knowledge (Hui & Stickley, 2007).

Key concepts identified by Foucault including power, knowledge, governmentality, technologies of power and the self, and ethics were examined not to detail how power operates through discursive interactions, but to ask analytic questions of the texts. These were:

- What are the historical, social and political origins of crisis mental health policy in NZ?
- What are the key discourses that have dominated debate about crisis mental health policy in NZ and which have been suppressed or excluded?
- What are the tensions between discourses and the implications this raises for nurses, service users and families?

3.5   Text and discourse analysis informed by theory from Foucault

A critical approach to discourse analysis emphasises the interrelationships between power and knowledge and the way in which subjectivity or identity is constructed through a range of discourses. Discourse is language that has common assumptions and sense; and is the ability of certain groups to have power to define

how such language use is controlled and shaped (Foucault, 1982). Ways of understanding or *meaning making* from this perspective always take the forms defined by historically specific discourses, such as those of science and medicine, with a tendency for specific discourses to serve prevailing relations of domination and subordination, the so-called dominant discourses (Foucault, 1979).

For Foucault, conceiving power as repression, constraint or prohibition is inadequate. Power produces reality, it produces domains of objects and rituals of truth. There is no standing back from this power and the discourses it affects (Danaher et al, 2000). However, one can engage with the dominant discourses from within, attempting to disrupt and demystify them by revealing the indeterminacy and paradoxically, the possibilities offered (Burchell, Gordon & Miller, 1991; Winch, 2005). An aim of Foucauldian discourse analysis is to analyse the potential to challenge the dominant discourse, through alternative discourse.

The use of critical discourse analysis in this study enhanced opportunities to examine how mental health nurses entered an encounter with service users, family members and other professional relationships. This approach examined how subject positions can determine oppressive moments impeding effective collaboration (Manias & Street, 2000). The second perspective was to place the analysis in a broader social context by making links to the wider networks of the crisis intervention social structure, through the analysis of the discourses from interviews with nurses, service users and families.

3.6   The process of analysis

In the first level analysis of grey literature, research and participant interviews, I located the discourse within the broader social structures and explored the historical, social and cultural conditions in which the discourse was located (Fairclough, 2007). I then focused on the micro-discourse of the text that provided information about the language employed to position the speaker in a certain way within a particular discourse. Lastly, the data was analysed in order to identify discursive patterns and processes in order to enable the identification of dominant, contradictory and/or silent discourses and what function they serve.

Discursive frameworks "order reality in a particular way, rendering it visible and understandable. At the same time, they constrain the production of understanding and knowledge that might offer alternate views of that reality" (Finlay & Ballinger, 2006, p. 202). The use of Foucault's analytical principles identified dominant and subordinate discourses which were then informed by critical social theory "which supports the heterogeneity that allows the paradigms to rub up against each other, leaving obvious disjunctions and discontinuities" (Manias & Street, 2000, p.58). The interwoven layers of analysis aim to limit the potential entanglement and seduction of dominant, discursive practice that I privilege, rather than to raise awareness of the discursive practices that matter to the participants. Manias and Street, (2000) suggest in doing so, researchers are able to reflexively and critically interrogate subjectivities and how these subject positions affect the positioning of participants.

Identification and analysis of discourses is a preoccupation across the humanities and social sciences (Fairclough, 2003). In a discussion about his own use and understanding of discourse, Foucault (1984c) suggested that he had in fact added to its meanings; treating it sometimes as the general domain of all statements, sometimes as an individualisable group of statements, and sometimes as a regulated practice that accounts for a number of statements. Although Foucault's analysis of discourse is the analysis of the domain of statements of text and utterance, it does not mean he was concerned with a detailed analysis of text, rather his concern was a matter of discerning the rules which govern bodies of text and utterance (Fairclough, 2003). The following is a description of how I went about identifying different discourses within the texts used in this study. The questions were developed as a means to interrogate the research data and to analyse the different discourses associated with mental health crisis intervention (Neville, 2005), rather than utilised as a direct set of questions to be answered (Powers 2013).

3.61   Analytical questions applied to the data

Discourse is considered a representation of some particular part of the world that forms a particular perspective. Equally, in this discourse analysis I identified the particular parts of the world, the main themes, and identified particular perspectives, angles or points of view about them. The following 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:

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?

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

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?
2. What are the institutional practices and how are they supported or modified by other discourses?
3. How have dominant discourses come to occupy a privileged position in relation to mental health crisis intervention at the expense of subjugated discourses?

Poststructural research relies on theoretical analysis, here Foucauldian analysis, rather than theory building analysis (Hamilton & Manias, 2008). Analysis of the data including interviews and written text was 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. Next, I explain reflexivity pertaining to the research process and complete the data chapter with a discussion on ethical issues.

3.7   Reflexivity

In order to explore the processes and practices of crisis intervention, I am making use of a Foucauldian genealogical discourse analysis. Although partly concerned with language, a genealogical discourse analysis is a macro approach to discourse that describes "the procedures, practices, apparatuses and institutions involved in the production of discourses and knowledge's and their power effects" (Carabine, 2005, p. 276).   Foucault's analytical junctions provide an opportunity or point of entry in relation to re-examining nursing theory and practice and the ways in which people might choose to describe their experiences (Ceci & Perkis, 2009; Fadyl & Nicholls, 2013; Stevenson & Cutcliffe, 2006). Some scholars describe Foucault as a historian, philosopher, social theorist, postmodernist and poststructuralist, and his analytic approach changed over time (Hook, 2011). According to Rabinow (1997) Foucault's innovate methodological pursuit was to historicise and politicise the knowledge of human sciences. Therefore, it is against the spirit of Foucaulian genealogy to offer predictions or directions for practice based on an analysis of how the past can predict the future. Rather, as Focault (1994) argues, the goal is about developing a position for transformation.

In the study I did not seek to achieve an analysis that can simply be re-applied to make ahistorical political points about the present and/or future, rather I am concerned with *histories of the present* (Foucault, 1977). In this concern for histories of the present, I aimed, through my analysis, to problematise crisis intervention, which I consider to be a political struggle between competing positions and differently minded people. Fadyl and Nicholls, (2013) highlight that: "Foucault's work took the position that the present is just the current iteration – the 'effect' – of a set of discourses, subjects and knowledge that are all historically situated" (p.25).

Therefore the value of history is not in its ability to construct a linear narrative that reveals our progressive drive toward enlightenment but rather, to locate the historical conditions that allow us to think, speak and act as we do now (Foucault, 2003).

There is considerable literature pertaining to reflexivity as a core component of poststructural approaches to research (Antaki, Billig, Edwards & Potter, 2002; Cheek, 2007; Parker, 1992; Smith, 2007). Literature suggests that reflexive researchers continually question their approach and reasoning to the data in a self-critical manner (Campbell & Gregor, 2004; Freshwater, 2010; Freshwater & Cahill, 2012a). Cheek (2007) suggests that reflexivity exposes political and ideological representation that can be hidden within a researchers writing. From a poststructuralist perspective, reflexivity problematises truth claims and consequently the desire to speak for others should be suspect and open to appraisal. Mental health nursing in general has been under considerable scrutiny from scholars within the profession and those outside (Clarke, 2009; Freshwater, 2012). However, issues of reflexivity such as the potential or actual power relations that exist during the research interview process are not widely discussed in the literature.

In this study, I take a critical position in which I acknowledge and make visible any background assumptions as well as the power differences between the subject of the research and myself as a researcher. Foucault (1984c) considered conventional research ethics as a technology of the self, acting upon the researcher throughout the process. He suggested that researchers consider what determines how an individual may constitute himself or herself as a moral and ethical subject. Through utilisation of an analytic approach to discourse, my position as a mental health nurse and researcher is emphasised and the scientific claims of objectivity and the elimination of neutrality and bias are rejected (Ceci, 2013; Cheek, 2007).

I recognise that certain scripts and expectations are well established for the ethical conduct of research and as such as certain conformity to the expected rules create a particular subject position for me. Critics of discourse analysis suggest that researchers read what they want to find into the text they analyse (Toolan, 1997) and although this is a commonly cited criticism, it is not necessarily seen as such by critical discourse analysis researchers (Fairclough, 2007; Thorn, Lawler, Pryce & May, 2012). Chouliaraki and Fairclough state:

> Critical discourse analysis takes the view that any text can be understood in different ways – a text does not uniquely determine a meaning, though there is a limit to what a text can mean: different understandings of the text result from different combinations of the properties of the text and the properties (social positioning, knowledge, values, etc) of the interpreter (1999, p.67).

It is important that researchers who undertake discourse analysis acknowledge the bias inherent in any research process and that they minimise any such bias through the use of a consistent methodological approach (Crowe, 2005). In doing so, analysis needs to include the utterances of all speakers within the debate, use the same questioning and to be up-front concerning any overt personal bias.

3.8   Ethical issues

The research project received ethical approval from the National Human Ethics Committee (Central region). Part of the agreement was that locality agreements were provided from each DHB before invitations for recruitment were sent out. Locality approval was also obtained from the National office of Schizophrenia Fellowship (SF) to invite family participants and the National office of LikeMinds NZ, for participants who identify as service users of crisis intervention. As I stated earlier in this chapter, an amendment to ethical approval was sought to include interviews from the NZ police service. Around the midpoint of interviews with service user, family and nurse participants I noted frequent references to police involvement in the experiences people had during crisis. In order to examine the relationship that the police have with people involved in a mental health crisis I gained permission from the Ethics committee and the NZ police, to interview a senior regional commander and watch house sergeant both of whom offered policy and practice perspectives of police intervention during crisis intervention requests from the public and mental health crisis teams.

The Massey University *Code of ethical conduct for research and teaching involving human subjects* (Massey University, n.d.) guided the research process. Research ethics outlined by Denzin and Lincon (2003) and Davidson and Tolich (2003) have informed my actions as a researcher throughout the project. *First, act honestly and be truthful.* Snook (2003) rightly proposes that the point of research is to improve the situation of human beings. Both means and ends must be subjected to ethical appraisal and researchers are obliged to deal with their participants and their research community in an honest and truthful way. *All participants will be voluntary.*

Locality approval for the DHBs, NZ SF and NZ LikeMinds and informed consent [appendix x] procedures were provided by all participants. *Minimising of harm.* Although it was not anticipated that this research project would cause harm to any of the participants, I was mindful to minimise any inconvenience in regard to the interview location, approach to questioning and discussion time given to the project by the participants. I was also aware to maintain privacy and confidentiality both in the description of the data and the content of the discussions.

It was expected that this study would surface thoughts and feelings about the experience of mental health crisis for all participants. For service users and families I facilitated the interview at a peer support organisation that was familiar to the participant. If during the interview any participant wanted to stop talking, stop the tape or terminate the interview I ensured compliance with their requests. I am also an experienced mental health nurse skilled at active listening and engage people in safe and non-threatening dialogue. Should any of the service user or family participants have experienced distress and required supportive follow up I would have negotiated this with the peer support agency. However, there was no necessity during this study. The participants were often pleased to be able to share their experiences.

For the nurses there was also potential for the interview to surface personal or professional issues that may cause distress. I had the support of the DHB to interview nurses at their workplace and would have approached the person in charge to assist support of the participant. I am also an experienced clinical supervisor and have the experience to conduct the interview to minimise such distress. If a nurse had disclosed unsafe practice I would have responded to my ethical duty and contacted my supervisor to discuss the issues.

Confidentiality was maintained by allocating a code name to each of the participants. I scrutinised all transcripts and field notes for any references that had the potential to identify individual participants, third parties, places or institutions. Participants were told that I would be transcribing the voice-recordings of the interview and that I had contracted a transcriber to type up some interviews also. The transcriber signed a confidentiality agreement [appendix xi] and all recordings,

my diaries containing field notes and the transcripts are kept in a locked file in my home office.

Access to information was limited to my supervisors and myself. I negotiated with the participants at the completion of the interview to use a pseudonym in place of their real name to ensure confidentiality was maintained. They were informed that I would keep the working transcripts and voice-recordings for ten years or until the completion of the dissemination of findings. The keeping of research related consent forms, recordings and transcripts over a ten-year period is consistent with the National Health and Disability Ethics Committee guidelines and the Health Regulations (1996). Any findings submitted for publication will not have identifying information pertaining to participants, others or locations.

3.9   Location of interviews and participant characteristics

Service user participants. Individual interviews took place at the service user support organisation or in the participant's own home at their request. I chose the venue of the peer support group rooms for service user participants for two reasons. Firstly, the environment was familiar and supportive to the service user. Secondly, it provided an accessible and safe environment for the participant and me as the researcher. When participants requested, I met with them in their own home to respect their preference and this request only applied to two service user participants. There were nine service user participants, seven women and two men. One participant identified as Māori and eight as European/Pākehā. Seven participants accessed services from a large urban crisis services and two from an integrated rural mental health team. Three participants were aged 31-40; three were 41-55; and three were 56-65 years old.

Family participants. Individual interviews took place at the SF support organisation rooms or at the request of the family participants, in their own home. I chose the SF venue for two reasons. Firstly, the environment was familiar and supportive to the families. Secondly, it provided an accessible and safe environment for the participant and me as the researcher. When family participants requested, I met with them in their own home and this request included all but one family participant. There were eight family participants, five women and three men. All identified as European/Pākehā. Five accessed services from a large urban crisis

service and three from an integrated rural mental health teams. One participant was aged 18-30; two were 41-55; five were 56-65 years old.

Nurse participants. Individual interviews took place in an office located at the DHB crisis service. If nurse participants preferred to be interviewed outside of work hours or in a location outside of their working environment I negotiated this with them. I interviewed eight nurses at an office close to their workplace and one at her home as requested. There were nine mental health nurses working within crisis services in this study, five women and two men. One identified as Samoan and eight as European/Pākehā. Five nurses work in large urban crisis services and four undertake a mixture of crisis work and case management roles within a rural service. Two nurses were aged between 31-40; six were 41-55; and one was aged 55-65 years.

The research aims and motivation for undertaking the project was given to each of the participants in the information sheet and before the commencement of the individual interview. Discussion and negotiation took place as to what feedback process best suited the participants. Some participants chose to have a transcribed copy of the interview returned to them, which they verified, corrected and returned to me before analysis. Other participants requested that I email or telephone them with the preliminary analysis or if there were issues that needed to be clarified during the transcription process or later within the process of analysis.

3.10   Justification of sample size

To undertake a critical discourse analysis a variety of text pertaining to the discourse under investigation is required. In this study, it was important that different perspectives were gathered to explore the discourses, strategies and technologies involved in crisis intervention. Authors on discourse analysis suggest a small sample of participants is indicative of the labour intensive nature of utilising the method (Fairclough, 2007; Hamilton & Manias, 2008; Potter & Wetherell, 1987). Each sample group was anticipated to provide a unique perspective and each group is viewed with equal value in this study. The different communities, some large urban and some small rural were anticipated to surface potential differences between the geographic settings. However, they were not comparisons, are not generalisable and are viewed as unique to their setting.

3.11   Summary

Chapter three provided an overview of the processes used to undertake this research.   A poststructuralist Foucauldian perspective was selected as a lens to explore multiple worldviews available to consider in the experience of mental health crisis intervention.   The notion of discourse and power according to Foucault has informed the analytical framework ultilised to question the texts generated from the process of data collection in this project.

Ethical elements throughout this project have been explained including a discussion on validation of findings when using a poststructural framework.   My intention and commitment to a reflexive stance and the utilisation of multiple data sources demonstrate that the research process provides an auditable trail.   This completes the background discussion pertaining to this study.   The following chapter is a literary history of crisis intervention in which I argue that the tension between medicalisation verses normalisation of mental health crisis has developed into a situation of uncomfortable co-existence.

Chapter four: The historical context and formation of crisis intervention services in New Zealand

4.0   Introduction

A discourse analysis informed by Foucault's genealogical analysis involves the tracing of historical events surrounding a field of inquiry and has the aim to problematise the stability and certainty of power and knowledge involved (Neville, 2005). In this chapter I present a literary history pertaining to the context of crisis intervention and how it is situated in (a field of) community mental health services. I challenge the truths that are viewed as stable or dependable bases of theories and practices of crisis intervention. The key arguments in this chapter draw out tensions between medicalisation and normalisation of mental health crises and how this has resulted in the development of an uncomfortable coexistence.

In order to map out a historical context of crisis intervention, analysis of public texts has been undertaken to discover what has evolved through the political, social and scientific context. Text are, for example, mental health policy documents such as *The New Zealand suicide prevention action plan 2013-2016* (MoH, 2013a) and discussion documents informing policy and clinical guidelines, for example, *Blueprint II* (MHC, 2012a/b). In this study, public documents are regarded as bodies of text, language, vocabulary and themes.

I discuss how the convergence of historical discourses of madness with a biomedical discourse has occurred, and what has been produced more recently in terms of discourses of accountability and risk associated services working with people in crisis. In part one of the literary history I argue that imposing restrictions and surveillance on people experiencing mental illness has been legitimised in a mental health system driven by politics and regulation. Literature concerning anti-psychiatry and the political service user movements is introduced as a means to surface the historical context of mental disorder being situated within crisis intervention.

Part two of the literary history addresses the theoretical and conceptual ideas of crisis intervention. Biomedical discourse has been privileged within research and policy about crisis intervention. Biomedical discourse is operationalised through an

inventory of clinical identification of deficits that abnormalise certain features of behaviours. A convergent model of intervention that brings together biological, psychological and social assessment of a person's functioning is suggested in the literature as best practice or as evidence based. However, the current context of crisis services in (NZ) is framed in law and policy, with a focus on safety and risk. The result is that people who experience mental disorder are expected to self-identify, or are identified through others around them such as family or social service agencies because they pose a risk to themselves or others.

4.1   What is not being said?

There are many instructional books available about mental health crisis intervention alongside a variety of associated therapies. Crisis therapies include different approaches such as psychoanalytic, cognitive, motivation focused and a raft of developmental, behavioural and solution focused models. However, in depth discussion on these topics has been deliberately limited, as this study is not focused on what clinicians should or should not do. Rather, the focus is to consider how the response to a crisis event in a person's life is shaped and transformed.

This chapter is focused on the defining characteristics of crisis intervention in the context of political and historical debates alongside strategies and technologies underpinning them. Models of crisis intervention practice offered a new *front door* entry point in the shift to community mental health care for people with serious mental illness. However, as will be seen in this analysis, in a discursive implementation of policy that drives access to services and statutory roles, the experiences of front line staff and users of services was very different.

In a genealogical analysis of crisis intervention I am concerned with how things have come to be known, and not with the shortcomings or missed opportunities of those involved. Parton and O'Byrne (2000, p.59) rightly point out that "change is endless, constant and inevitable" and it is this premise that underpins the philosophical positioning of crisis as an event in this study. Change is happening all the time in people's lives and at times it may go unnoticed. But that does not mean it does not exist, only that the tools or lens to view it have not yet been considered. Changes to crisis intervention presented as progressive in the literature have created new and possibly subtler, strategies of power (Holmes, Murray, Perron

& McCabe, 2008). That said, it cannot be assumed that one discourse of crisis is more beneficial than another (Holmes, Gestaldo & Perron, 2007).

Fairclough (2007) suggests researchers undertaking macro-analysis of public text need to interrogate their own subjectivities in order to examine discursive formations. Throughout the analysis of public documents, empirical research and in the writing process, I considered and reconsidered how my subject positions as researcher, mental health nurse, family member and individual rendered the text usable and understandable. My goal was to examine and discuss the discerning rules that govern bodies of text and speech, not a detailed analysis of the text itself.

4.2   The search for knowledge/power about crisis intervention

The theoretical perspectives presented in chapter two of this thesis suggest that knowledge and truth are produced by struggles both between and within institutions, fields and disciplines and then presented as if they are universal or eternal. Foucault (1972) argued that knowledge is power in and over others. McNay (1994) proposed that knowledge includes ideas, narratives, commentaries, rules, categories, laws and definitions produced and valorised by disciplines, fields and institutions through the application of scientific principles. Furthermore Foucault suggests knowledge and power are inextricably linked, and rather than power being held and used by people, it is a complex flow and set of relations between groups in society that changes with circumstances and times.   Therefore people gain knowledge from the respective discursive context in which they live their lives (Foucault, 1972).

Historical analysis pertaining to the experiences of people regarded as mentally unwell have been presented in literature throughout the centuries (Neville, 2005). In the 1965 publication of *Madness and Civilisation,* Foucault asked the question what does it mean to be mad? Foucault examined the archaeology of madness in the west from 1500-1800. He explored a time span from when insanity was considered part of everyday life and people termed as fools and crazies walked the street freely, to the time when such people began to be considered a threat (Foucault, 1988). In *The Birth of the Clinic*, published in 1975, Foucault traced an emergence of insanity becoming a psychopathology of the human mind/body and a shift to the anatomo-clinical gaze. He argued that by medicine incorporating

psychopathology into the discipline, a reinterpretation of pathology as an observable and quantifiable variation of what was considered normal occurred in history (Foucault, 1975). Many publications regarding the historical venues and treatments for people deemed mentally ill have been authored. In line with a genealogical approach, the following discussion sets out to map a historical context of crisis intervention within the published social and political conditions of knowledge and practice (Foucault, 1991a). The purpose of the discussion is to historicise crisis intervention in a way that examines what about it could have evolved given the political, social and scientific/professional context in which claims of *truth* have developed. I begin with part one offering a history of how the present came about through the social movements of anti-psychiatry and mental health service user political movement.

4.3 Part one in the history of crisis intervention: the death of the psychiatric institutions (1950s-1980s).

Mental illness is thought to have affected people throughout the ages (Bentall, 2004). An explanation to different or unusual emotional responses and behaviour in people has been responded to in society through a series of different explanatory modes. Our ancestors were thought to attribute changed behaviour within an individual to the influence of an external force or power such as demonic possession or religious influence (Gorenstein, 2002). It is relatively recent that a biological basis of mental illness has been recognised and embraced by many. Hippocrates (460BC) is thought to have been the first to theorise that mental illness had a physiological basis rather than being the result of disputable moral character. His theory proposed an imbalance of the brain and a biological basis and internal locus for the origins of mental illness, rather than a person's experience being a reflection of external forces. A further concept in Hippocratic medicine was that of a crisis. Hippocrates suggested crisis was a point in the progression of disease at which either the illness would begin to triumph and the patient would succumb to death, or the opposite would occur and natural processes would make the patient recover (Antoniou, Antoniou, Georgiadis & Antoniou, 2012). After a crisis, a relapse might follow, and then another deciding crisis. From a Foucauldian perspective, a medical understanding of mental illness is inextricably connected to body parts and their function. Representation of the body in this way translates to normal and

abnormal physical components of the person visible to the clinical gaze undertaken by psychiatry.

Psychoanalytical psychiatry founded in the work of Sigmund Freud (1856-1939) is largely credited with establishing the field of verbal psychotherapy (Saarinen, 2012). Freud was a trained neurologist and best known for his theories about the unconscious mind, dreams, infantile sexuality, libido, repression, and transference, all of which continue to influence the field of psychology (Brogaard, 2011). His account of the mind's structure, the id, ego, and super ego, led to a new understanding of human psychological development and the treatment of emotional disturbance. Treatment for mental illness from a psychoanalytical perspective suggests the disequilibrium that accompanies psychopathology in a person can be understood and treated through gaining access to the person's unconscious thoughts and past emotional experiences. Graham (2010) argues that psychoanalytical psychiatry was widely endorsed and medically institutionalised until the 1960s.

Large, institutional hospital asylums were a mainstay venue to house people deemed mentally unwell from the late 18th Century up until significant scientific, social and political changes during the 1950s and 1960s. Asylums provided the discipline of psychiatry and its attendants, such as psychiatric nurses (Hunter-Williams, 1987), with an ideal location to deploy the discursive practice of surveillance intrinsic to Foucault's (1975) clinical gaze (Holmes, 2001). However, the argument from biological psychiatry for the need of a reliable clinical diagnosis was gaining new momentum. A biomedical discourse of mental illness provided a scientific explanation that a patient's distress and complaints were symptoms of a specific and tractable illness type or disease category (Graham, 2010).

Biomedical understanding of mental illness developed from scientific theory of disease and illness of the brain in an attempt to explain abnormal thoughts, feelings and responses thought to manifest in people (Haslam, 2000). Biological therapy for mental illness has taken a number of different forms but has the consistent involvement of some type of physical intervention (Double, 2003). Medicine applied techniques to the body of a person such as psychosurgery, pharmaceuticals, electroconvulsive therapy (that continue today) and a raft of other interventions aimed at producing normality upon the emotion and behaviour of those

thought to be mentally disordered (Goffman, 1963). Significant inflation of the authority of biological psychiatric thinking came about with the introduction of psychotropic drugs in the 1950s (López-Muñoz et al., 2005).

The introduction of phenothiazine drugs such as Chlorpromazine for psychosis and tricyclic antidepressants were heralded as revolutionary developments in the management of mental illness (Horwitz, 2002; Lopez-Munoz et al., 2005). Pharmaceutical scientific discoveries helped to inflate the status of medicine and gained much media attention (Kane & Correll, 2010). The pharmaceutical treatments under the control of biological psychiatry gave new options to patients who had symptoms of mental illness that were, until that time, considered refractory to most other interventions (Carpenter & Davis, 2012; Kane & Correll, 2010). Biological psychiatrists were considered to be the catalysts to opening up the potential for people with mental illness to be cured. The claim from biological psychiatry was that their way could reduce the need for protracted psychoanalytical practices and scrutiny over management and costs of psychiatric institutions.

A biomedical discourse of mental illness contains two key inherent assumptions suggested by Nettleton:

> Biomedicine interprets the body in a dualistic manner (body-mind dualism), and the body as a machine is utilised resulting in medicine reducing the body into a fixable human mechanical part through technological means (2006, p.3).

The use of reductionism by medicine as a means to explain mental illness and health demonstrates how powerful and pervasive psychiatry has been in the construction of mental disorder as an established medical entity. However, Chamberlin (1990) argues that challenges within the medical discipline and externally from social science academics during the early 1960s, created a deep division and a crisis in self-identity between biological and psychoanalytic psychiatry. Conflict within the medical profession and critique of institutional regimes of psychiatric treatment and services failing to consider the dynamics of living, was gaining momentum. The next section of this literary history traces the material conditions involved in the development of a new integrated biological and psychosocial approach to mental health services.

4.4   De-stabilising biological psychiatry

South African psychoanalyst David Cooper first coined the term *anti-psychiatry* (Cooper, 1967).   However, philosophical and sociological debates concerning the powerful relationship between the psychiatric and governmental establishments were already well under way with four seminal thinkers promoting a movement of social change across the world.   These four key people included in France, Michel Foucault, in the UK, R.D. Laing, Thomas Szasz in America and Franco Basaglia in Italy (Satel & Redding, 2005).   Each challenged the notion that personal reality was independent from any hegemonic definition of normalcy and that scientific evidence argued to promote institutional psychiatric care was an example of a psychiatric-governmental collaboration to control the population.

Foucault's seminal work traced the social context of mental illness and distinguished that it was always defined by external economic and cultural factors. Whilst Foucault was writing during the early 1960s in France, in England R.D. Laing joined others who were describing the social origins of behaviour.   This group of authors included Fanon's (1963) text on how *Blacks* would often fulfill racist stereotypes and Lessing (1962) on how women commonly conformed to society's expectations of passivity and femininity.

Laing (1967), a psychoanalytical psychiatrist, and Goffman (1961), an American sociologist, shared the philosophical argument that psychiatric patients were wrongly stripped of social rights and responsibilities and as a result developed institutionalised behaviours.   He promoted the idea that severe mental illness had social causality and that the social institutions were a form of governmental collusion with medicine to exclude full rights of citizenship for people experiencing mental health problems.   Laing noted that people with psychosis could be viewed in one of two ways: "One may see his behaviour as signs of a disease [or] one may see his behaviour expressive of his existence" (1960, p.56).   He was suggesting that symptoms such as delusional ideas or fixed false beliefs, were not signs of an illness but instead, an understandable reaction to an inescapable and persecutory social order (Laing, 1960).   In this view, a psychiatric diagnosis such as schizophrenia would not exist as an illness but rather would be considered an existential fight for personal freedom.   Therefore, the person's experience of psychosis could be

addressed via social remediation.   Another psychoanalytical psychiatrist and academic, Thomas Szasz was also pursuing the notion of how mental illness was viewed in a social context.

Szasz in New York, spurred on the anti-psychiatry movement with the publication of his article: *The myth of mental illness* (1960) which later became the core in his well-known book: *The myth of mental illness: Foundations of theory of personal conduct* (1961).   Szasz argued that because schizophrenia could not be proved to be biological in origin, it was therefore not justified to call it disease or illness. He argued that the classification of schizophrenia and other mental illnesses such as mania, anxiety and depression were no more than fiction and a way that organised psychiatry could gain control and power over people (Szasz, 1961).   The power that Szasz was suggesting was part of an overall strategy that the state was legitimising in order to exclude non-conformists and dissidents.   He suggested the situation was a psychiatry-government collusion and citing the principle of "separation of church and state", argued a similar clear division between "psychiatry and state" (1961, p.98).   At the same time, separate social activist groups opposing psychiatry and governmental collusion to label and marginalise groups through gender, ethnicity and mental illness were gaining momentum throughout the United States and Western Europe.

In the United States at an American Psychiatric Association (APA) conference in 1970, social action was demonstrated by hundreds in the anti-psychiatry movement joining social activists arguing for gay rights and the removal of homosexuality as a classification of social deviance in the field of psychiatry (Satel & Redding, 2005). A year later, activist Frank Kameny stormed the podium at an APA conference and declared war on psychiatry for its classification in the Diagnostic Statistical Manual (DSM), of homosexuality (Appelbaum & Gutheil, 2007).   This instigated a task force within the APA, which led to homosexuality being deleted as a mental illness in 1973. In Europe later that decade, the process of deinstitutionalisation began.   Italian psychiatrist Basaglia became the leader of a further development in anti-psychiatry arguing for a greater focus on service user participation in treatment (Appelbaum et al., 2007). Basaglia reinforced the notion that mental illness was not a disease but rather an expression of human needs. A shared view was developed by organised psychiatric survivor led groups in Europe,

and along with the political lobbying of Basaglia and his supporters came a move toward the closure of hundreds of psychiatric institutions in Europe, NZ and Australia.

The formative years of a new psychiatric survivor led coalition offered a struggling anti-psychiatry movement a partner towards significant mental health reforms (Clay, 2005). However, wanting to keep the movement in the hands of prior patients of mental health care, the survivor movement had little interest in a psychiatrist led intellectual pursuit and as a result, the psychiatric survivor movement devolved from being a campus-based, to a patient-based organised pursuit (Everett, 1994). Groups around the world such as, The Insane Liberation Front, The Network Against Psychiatric Assault and the Mental Patients Liberation Front worked together through the *Madness Network News,* an organised political publication during the 1970s and 1980s (Rissmiller & Rissmiller, 2006). This collective strengthening of small groups of ex-patients culminated in a national conference held by the US National Institute of Mental Health, in 1985. From then to the present day an international network of psychiatric survivors has continued to grow as a unifying medium through which to engage and integrate "a significant socio-political influence on the mental health care system" (Satel & Redding, 2005, p.176). The radicalised and now politicilised survivor movement increased in impact and continues to lobby for advocacy and legislative change to mental health systems throughout the world.

Social and philosophical foundations were laid in place for the emergence of mental illness as an unstable entity by the 1970s. Although they were separate political groups, the antipsychiatry movement, sociological researchers and the psychiatric survivor led coalition collectively worked as a catalyst to halt institutional psychiatric services and challenged the notion of truth involved in a biological explanation of mental illness. There was public outcry against biological psychiatry practices of compulsory admission to government run institutions, where patients were subjected to large quantities of neuroleptic drugs and social estrangement (Goffman, 1961; Szasz, 1961).

Despite these significant events, by the late 1970s the anti-psychiatry movement began to converge once more with biological psychiatry (McLean, 1995).

The shift was partially due the increased implementation of psychopharmacology but more because of the social and political changes in response to a post liberal implementation of welfare reforms. As a means to retain leadership, medicine converged a biomedical discourse with a social discourse and a biopsychosocial approach began to be used by clinicians within psychiatric services (Barker & Stevenson, 2000). This narrowed the gap between the analytic and biological clinicians and strengthened their leadership within a new community model of mental health services (Sekula, Holmes, Olshansky, Zoucha, & Desantis, 2001).

Since the 1960s there has been a shift toward a self-responsibilisation model of mental health services that evolved in part from an antiestablishment and anti-psychiatry movement (Satel & Redding, 2005). The precursor to a biopsychosocial approach can be traced to a crisis in self-conception between psychoanalytic and biological psychiatry, which occurred during the 1960s (Sadock & Sadock, 2007). It was not until a critical mass of non-governmental groups came together in the early 1980s that enough political, legal and economic pressure was created to cause a particular crisis category to become formalised. The next section furthers discussion on the material conditions that facilitated the development of a biopsychosocial approach to stabilise a medically driven search for mental disorder within crisis intervention.

Crisis intervention has its roots in a history of an evolving psychiatric mental health policy and the aftermath of a liberal political shift toward closure of psychiatric hospitals and development of new welfare reforms. Contemporary mental health service exists and is informed by a *body* of psychiatric knowledge (Hui & Stickley, 2007). There is a diverse and sometimes conflicting plurality of disciplines, which go to make up contemporary mental health policy, services and practices. Medical and nursing psychiatric knowledge is neither atemporal nor objective, given that it has not emerged from within a neutral space existing outside the history of a particular culture and society. Psychiatric knowledge is enmeshed within a culture of history and the society in which it occurs. Foucault (1984b) suggests such knowledge is intimately bound to the political concerns, norms and values of that culture and society. Foucault (1991a) suggests psychiatric knowledge is essential to the manner in which people are made *subjects*. According to a genealogical approach there is a need to historicise and politicise the knowledge of

human sciences such as medical and nursing knowledge. Furthermore, that knowledge is not to be understood as universal (Rabinow, 1984).

In the context of historical change to mental health services during the 1960s and 1970s, mental health practices and policies by 1980 were in flux (Kirk, 2005). The advent of a biopsychosocial approach to mental health treatment signaled a turn toward biological and psychosocial interpretation of mental distress and development of community intervention *best practice* models in the 1980s began to develop (Rose, 2003a). Debates during the early 1980s regarding the professionalisation of nursing also impacted on nurses, in particular, the development of *evidence based practice* and specialisation within nursing (Holmes et al., 2008).

The increasing popularity of social and psychological science provided added legitimacy for mental health nurses and other allied health professionals such as social workers and occupational therapists to view their work as applied science. This strengthened their claim to professional status within community mental health and challenged the position of medicine as sole authority within services (Cutcliffe & Weick, 2008). Strategies and technologies within a biomedical discourse adopted by mental health nurses mimicked medicine as a profession of technical knowledge based on science and theory, which guided by diagnosis followed certain treatment regimes. Kirk (2005) argued that various other professional groups within community mental health services, such as social workers, psychologists, counselors and occupational therapists were also quick to offer therapeutic treatment services under the guise of a biopsychosocial approach and the roles of *mental health providers* became increasingly blurred. The biopsychosocial approach, within a biomedical discourse underpinning the strategies to develop community mental health crisis services, caused a shift in power and leadership of services during the 1980s (Pilgrim, 2007). Meanwhile, medicine was building alliances with pharmaceutical companies and government agencies. Dain (1989) suggests that in a bid to regain control of the system, psychiatry took another strategic sharp turn toward biomedicine in the late 1980s. Leadership and medical authority within NZ community mental health services was further strengthened by a significant change to mental health legislation (McKenna, Thom, O'Brien, Crene, Simpson, 2009) that eventuated in the implementation of the Mental Health Compulsory Assessment and

Treatment Act (MHA) in 1992.

The new interventions within a biopsychosocial approach developed during the late 1970s-1980s and were practiced by mental health nurses, psychologists, social workers and others working in community mental health began to be subsumed again. By biomedical re-privileging of strategies such as medical diagnostic reasoning and psychopharmacology, the psychological and social practices of this timeframe moved to a marginalised position. Those interested in the healing power of therapeutic relationships and change-orientated practices were positioned with little influence unless they were prepared to take up new roles under the MHA (1992) and align themselves with specialisation of services (Kirk, 2005).

4.5   Part two in the history of crisis intervention: the object of mental disorder and the birth of crisis theory and practice

The theoretical perspectives outlined in chapter two proposed that the emergence of a discourse is related to the existence of certain rules and social structures that provide for an object of a discourse to be named, and therefore, spoken about within a society. Foucault (1972) suggested the rationale for examination of how particular discourses originate, requires analysis of the material conditions of possibility apparent and that those material conditions are entwined with institutional practices that have an influence and an ability to regulate social life. Material conditions existed toward the end of the 1980s that made it possible for the emergence of the object of mental disorder in people experiencing crisis. A particular condition was the development of new legislation concerning the assessment and treatment of people thought to be experiencing psychiatric symptomology and associated risk toward themselves or others.

Over a century ago, mental illness was viewed as major, serious conditions involving conduct such as florid psychosis and hysterical disorders. Most of what is defined today as mental illness, such as drug induced psychosis or anxious-depression, and would have been viewed then as moral failings (Lewis & Whitley, 2012). People were seen to have personality flaws or questionable habits, not pathological nor the business of medicine despite hospitalisation occurring for them (Kirk, 2005). In contrast, today there is an array of common behaviours viewed as

possible symptoms of mental illness. Possible symptoms include experiences such as feeling sad, having trouble at school or work, drinking too much alcohol or not sleeping well. Once seen as a rare problem for a few, psychiatric pathology is now suggested to be an ever-present potential experience for many, much like the common cold (Wakefield & First, 2003).

Psychiatric treatment devolved from custodial care within government funded institutions, most of which closed in NZ during the 1980s and 1990s (MHC, 2007). Institutional asylums were overseen by politically appointed, medically trained superintendants who controlled a medley of services and therapies offered by many different professionals and untrained support people (Hunter-Williams, 1987). The diversity of professionals and therapy approaches is one reason why the concept of mental illness and the venue in which those deemed mentally disordered are acted upon has changed and developed significantly since the 1980s and 1990s. One exception to community care is the specialty of forensic psychiatric services. Forensic services provide inpatient assessment and treatment or community follow up for people subject to criminal charges or sentences. Forensic patients are deemed to be mentally unwell and categorised as *Restricted* or *Special* patients under the MHA (1992), and this carries added restrictions.

Boyle (2002) argues that theories of mental illness, which stem from scientific facts to support diagnoses such as schizophrenia, have been widely disputed. However, the medical profession has mainstreamed the idea of mental disorder being a condition that people ought not to suffer (Bentall, 2004; Boyle 2002). As a result psychiatrists have wrongly retained a *right* to decide mental health needs of the population and subject them to (Minkowitz, 2006) or exclude them from (Wand, 2013a) certain health care access and treatment regimes.

The medical establishment has transformed mental illness from serious debilitating conditions to an inventory approach where problems of living are potential pieces in a jigsaw of pathologising human behaviour and are dealt with as mental disorders (Arpaly, 2005; Goffman, 1963). In the devolution of institutional psychiatric services, medicine successfully converged biological discourses with psychological and social discourses (Bentall, 2004) to suggest conceptual

understanding of mental disorder and risk associated with individual and social burden (Pilgrim & Ramon, 2009).

Mental disorder is a medical-psychiatric term (APA, 2000) and also a definition within law (Bell & Brookbanks, 1998; WHO, 2009; 2013). The establishment of mental disorder as the terrain of specialists within mental health services is an important component in the history of crisis intervention becoming recognised as a means to provide particular knowledge and power over the lives of citizens since the 1980s.   The production of the object of mental disorder in the context of crisis situates a social need and structure of expertise for advice and monitoring. Firstly, medicine refers to mental disorder as disorders of the brain or cells, attributed to various neurologically specific breakdowns that occur in the brain (Charney, Nestler & Bunny, 1999). These breakdowns can be due to developmental trauma, pathogen, injury or a variety of other causations that constitute or compose the conditions termed as mental disorder. Causation and distinguishing mental disorder from brain injury or neural functioning is quite orthodox in medicine (Bear, Connors & Paradiso, 2007) and the ability to claim an organ, limb, or type of pathogen and so forth has strengthened the notion that specialisation is required. In a biomedical discourse, mental disorder is a type of brain disorder but it is not merely located in the brain cells as such, it is also evident in the form of malfunctioning cells, neural damage or impairment displayed in a person through abnormal biological, emotional and social manifestations (Hatala, 2012).   However, this medical theory incorporated into psychiatry as a specialty has been widely disputed by social theorists who suggest cause, pathology, intervention and cure is very uncertain in most mental illness (Bentall, 2004; Pilgrim, 2008).

George Graham (2010), a social philosopher, has outlined a key inconsistency in the claim of psychiatry of scientific reasoning behind mental disorder. He argues that mental disorder may be a disorder in the brain without being a disorder of the brain. He uses the example of somatic illness such as pain, fever vomiting, diarrhea or fatigue to suggest that certain physiological symptoms whilst unpleasant for the person may not be a malfunction of the body. Instead such symptoms may mean that the body is functioning well or perhaps ridding itself of toxins. Furthermore he suggests that whilst some somatic symptoms cause distress

and may warrant medical treatment they may not be physical illnesses and would not be considered disorders. For example, a case of diarrhea or a fever may be a disturbance in the body without being an illness of the body. Likewise, a case of mental disturbance is not necessarily associated with disease and may well be the person in a state of emotional disruption suggesting the need to make changes within their life.

Graham (2010) argues that a discourse of risk associated with mental disorder has strengthened the public's belief in psychiatry having an intricate knowledge of brain dysfunction as a condition that people ought not to have to *suffer*. Moreover, the discourse of risk associated with mental disorder has created a type of moral hysteria that created fear in the public. Risk discourse is established by medical presuppositions or *facts*, to explain why disturbances that are classified as mental disorders are undesirable. According to Graham (2010), mental disorder is harmful or dangerous is the first fact of psychiatry. This suggests that mental conditions may cause people to feel bad and are associated with harmful and potentially lethal behaviour (Kinghorn, 2011). The potential harm and danger may take the form of pain or suffering in the individual that could even cause significant risk of death.

The second fact established by medicine is that mental disorder may take the form of one becoming incomprehensible to the self (Weiner, 2011). Self-incomprehensibility according to medicine is a severe burden associated with mental impairment where victims of mental disorder do not understand why they think, feel or respond as they do (Warelow & Holmes, 2011). Not being able to understand one's self is another component of risk discourse and the object of mental disorder within. Mental disorder through risk discourse is said to cause the individual to become incapable of rational decision-making (Schlimme, 2009; Weiner, 2011), self-awareness or the ability to take proper care and responsibility for the self (Kinghorn, 2011). Rational decision making and autonomy are lynchpin notions of scientific rationality and modernity.

The undesirable position of failing to understand the self, helps to make mental disorder seem as if it is not voluntary and positions the person as personally uncontrollable by nature (Bolton, 2009; Schlimme, 2009). This fact of mental

disorder established in the scientific evidence of psychiatry suggests people may be so deep in the grips of abnormality that they require interventions and oversight from experts to free them or at least reduce its effects (Graham, 2010; Kinghorn, 2011). Furthermore, it is implied that without expert investigation and surveillance, a person with a mental disorder may be unable to live in a self-determining fashion, especially during crises or time of high and imminent risk.

Through this re-crafting of mental disorder there has been a significant broadening of the medical-psychiatric terrain (Jablensky, 2012), and this has come at the cost of more complicated and controversial searches for causes, remedies and cures (Graham, 2010; Kirk, 2005). However, many professions such as nursing, psychology, and social work are vying for legitimacy and jurisdiction within the expanded array of mental health services (Baker, 2011). Generations of psychological and social interventions directed toward the behavioural responses of those experiencing mental disorder have also strengthened the need to provide surveillance of them.

As mentioned prior, as mental disorder becomes an object in a discourse of risk, the object is also made apparent in law and as a result creates conditional restrictions on citizens (Bell & Brookbanks, 1998; WHO, 2013). Social directives relating to mental health services attempt to delineate particular problems and solutions associated with mental disorder, which justify intervention from the state (Pilgrim, 2007). People deemed mentally disordered have been the target of regulatory and disciplinary power of government through mental health legislation. Such disciplinary practices call upon mental health professionals to adopt certain risk practices associated with the notion of mental disorder to which they must comply.

In 1992, the NZ government implemented new mental health legislation to redefine the circumstances in which and the conditions under which persons may be subjected to compulsory psychiatric assessment and treatment. The MHA (1992, p.1) defines the rights of such persons and is justified in law to "provide better protection for those rights, and generally to reform and consolidate the law relating to the assessment and treatment of persons suffering from mental disorder". The implementation of civil mental health law with an emphasis on rights within the 1992

legislation signaled a change in both policy and service implementation within a NZ context. In section 2 of the MHA (1992) the legal definition of mental disorder within NZ legislation is presented. The legislation states:

> Mental disorder [is], in relation to any person, an abnormal state of mind (whether of a continuous or an intermittent nature), [that is] characterised by delusions, or by disorders of mood or perception or volition or cognition, [to] 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 survivors have pointed out the violence toward people deemed mentally disordered at the hands of services (Crossley 2004; Minkowitz, 2006), which includes diminished human rights and the use of force and detention (WHO, 2013). Furthermore, social constructionists underline the disabling power of language practices and psychiatric labeling such as *abnormal mind, serious danger* and *diminished capacity*, which removes the ability to speak from those who are diagnosed as mentally ill (MacKay, 2011; Pilgrim & Tomasini, 2012).

The 1992 MHA was in response to the devolution of asylum style psychiatric services and created a shift toward accessible and community orientated interventions aimed to reduce the burden of mental disorder within and on the population. NZ followed international legislative trends, such as the 1983 English Mental Health Act, (Fistein, Holland & Gunn, 2009) with some local differences and implemented a community orientated Act and a crisis intervention approach, as a means to provide access to assessment and treatment services. NZ's new Act was based on a working relationship between the government run mental health services, the legal system and mental health professionals. The next section is a discussion pertaining to the discursive implementation of new mental health legislation within a NZ context and suggests people experiencing a crisis become a subject under law and subject to crisis services so that expertise about them can be imposed.

4.6   The colonisation of psychiatric medicine by legal processes

Prior to the implementation of the MHA in 1992 the legal system and lawyers had little to do with the process of involuntary hospitalisation of people deemed mentally ill. The 1992 MHA forced the creation of new relationships and

expectations between professionals of law and the mental health system. Pilgrim (2012) argues that there are fundamental differences between the ways doctors and lawyers perceive their role in the practice of mental health law and a deep divide among those who determine the fate of mentally disordered persons. These differences include the nature of the relationship with the [mentally disordered] individual, aims of their profession, formal structure of the tasks which the profession is called on to undertake, and continuity of their relationship with individual (Bell & Brookbanks, 1998).

Doctors were given particular status under the MHA (1992) in the form of a statutory title of *Responsible Clinician* and medical classification of mental disorder was given status through a legal definition (MoH, 2000b). Various other statutory roles were legitimised in the implementation of the new Act. These included a role for clinicians undertaking the duties of the Duly Authorised Officer (DAO), largely taken up by mental health nurses working within crisis teams (McKenna, et al., 2009) and a role for the police in the enforcement of mental health legislation. Both the roles of the DAO and of the police are important to the history of crisis intervention in this study and are discussed in depth within the following data chapters. However, the focus of this discussion is aimed to highlight how the MHA (1992) reflected a shift in emphasis from previously paternalistic institutionally based services aimed at care and protection to one promoting patient rights. The new Act was integral to the material conditions that facilitated legal provision designed to protect the public from people who are dangerously mentally disordered, while at the same time aiming to establish legal rights of those subject to the legislation.

The legal definition of mental disorder requires evidence that a person in crisis is experiencing an abnormal state of mind, which raises conceptual and ethical issues. The inclusion and use of the term abnormality within law, refers to the objective comparison of a person's behaviour with that of the community. In a biomedical discourse, the term abnormality defines the individual subjectively against predetermined biological norms. Authors of service user rights widely criticise attempts to classify behaviour objectively as abnormal (Minkowitz, 2006; O'Hagan, 2006). Furthermore, adopting an objective approach widens the definition of mental disorder.

Wakefield (2006) suggests that the legal definition of mental disorder could be translated to mean that almost anyone whose behaviour could be construed as abnormal could be considered mentally disordered, even though their behaviour may not be the product of any disturbance of mental functioning other than simply reflecting the type of person they are. Foucault (1980a) suggests the medicalisation of mental illness was in tandem with the deployment of discursive strategies and techniques associated with the biomedical discourse inscribing the insane. Strategies and techniques include viewing mental disorder as a biomedical problem comparable to a physical illness, which then legitimises the diagnostic gaze as a means of classification. By associating suicide or intention to lethally inflict harm on the self with mental disorder, a biomedical discourse is strengthened further to legitimise deploying treatment regimes focused on physical and biochemical interventions. By claiming suicide as a consequence of mental disorder and an integral part of psychiatry, medicine is positioned to provide a set of normalising techniques. These are then inscribed on the body of the person in crisis to both prevent risk but also to serve as a means to measure prevalence. Suicide prevention in which individual crisis is addressed from a mental health standpoint has a history dating back to 1906 when the first identifiable crisis phone line was established by the National Save-a-Life League in the United States (Bloom, 1984). Landmark research into the causation of suicide, which began in the 1950s by Edwin Shneidman, spanned six decades. The study of suicide and evidence based or best practice approaches achieved such a status that it became *suicide-ology* (www.suicidology.org). Globally there are national associations in most countries (Shneidman, 2004), including NZ. Further discussion on the prevention and classification of suicide is argued within the data chapters that follow within this thesis.

The next section of this chapter addresses the theoretical ideas underpinning crisis intervention as a practice. Following the discussion on components of crisis intervention, a context of implementation of crisis teams within NZ mental health services is outlined.

4.7   The birth of crisis theory and intervention

As discussed earlier in this chapter, the medicalisation of madness has undergone challenges from philosophical and social theorists over the last century. However the focus of discussion thus far has centred on a crisis of identity within psychiatry during the 1960s to 1980s and now the development of new mobile community services constructed during the implementation of the MHA (1992) is discussed. The purpose of examining a history of *crisis* and *crisis intervention* in the second part of this chapter is to consider how the concepts came to be known as such and to examine how particular sorts of individuals, organisations and systems became legitimised and strengthened through the operation of certain discourses pertaining to the field of crisis intervention.

Eric Lindermann in the 1940s is said to have authored a new model of managing symptomology in acute grief, following his research concerning survivors of the Coconut Grove fires in Boston, America. Lindermann found many of the survivors appeared to have common emotional responses and a need for psychological support. He coined the term *normal grief reaction* (James & Gilliland, 2013). Wolbert-Burgess and Baldwin (1981) suggest that seminal ideas from Lindermann (1944) were then developed by Gerald Caplan's (1961; 1964) theory of crisis intervention and its use in psychiatry established crisis intervention as a primary model of clinical practice within community mental health services. There are a variety of definitions of crisis encompassing two main conceptual forms. The first conceptual form of crisis is developmental or maturational (Aguilera, 1998). According to psychological theorists, developmental crisis can be predicted and occurs in conjunction with what is deemed normal developmental transitions in which individuals and families are seen as unprepared to cope with. The construction of crisis as a developmental experience of people stemmed from the attachment theories of John Bowlby (1965) and developmental phases theorist Eric Erikson (1968). The second conceptual form of crisis is situational (Johnson, Needle, Bindman & Thornicroft, 2008). In contrast to developmental crises situational crisis are precipitated by unpredictable events for which individuals and families are understood to be unable to prepare (Jackson-Cherry & Erford, 2010). Construction of crisis as a reaction to a situational event began with the human

response theories of Lindermann (1944) and was further sanctioned by grief and loss theorist Kubler Ross (1969) and behavioural theorist Hoff (2009).

The concepts have influenced all fields of mental health care since their introduction in the 1960s (Hoult, 1986) but have been most influential since the 1990s (Carroll, Pickworth & Protheroe, 2001). Hoff (2009) argues that the concept of crisis and practices of crisis intervention gained popularity and was retained in mental health organisations in contrast to most other psychodynamic approaches, because it provides the clinician with a focus with which most behavioural events can be classified. The American Psychiatric Association (APA) through the Diagnostic and Statistical Manual of Mental Disorder, Vol. 4, (DSMIV and in 2013 the DSM V) defines and classifies most psychiatric conditions today (Crowe, 2006). However, it was not until the latter half of the twentieth century that diagnoses such as anxiety, personality disorder, depression, or psychosis were viewed as mental illnesses. Furthermore, it is only since the 1990s that social responses (Ingnaas & Van Hoyweghen, 2011) such as attention deficit disorders and social phobias and problematic consumption of food, tobacco and other substances have been added to the expansive list catalogued within the DSM (Godrej, 2012; Ronson, 2011). Classification systems are used by a variety of allied mental health professionals to legitimate and assert expertise over people in crisis. The Diagnostic Statistical Manual of Mental Disorders (DSM IV) the most widely used and authoritative classification system within mental health services. The American Psychiatric Association published the first volume in 1952 (Graham, 2010). There have been various editions of the book and the current publication is version V published in 2013 (APA, 2013). Further discussion of the DSM as a technique deployed within crisis intervention takes places later in this chapter and within the following data chapters.

So far within the second part of this chapter, discussion has focused on surfacing the biomedical and conceptual construction of mental disorder as a disease entity. Examination of the object of mental disorder and the way in which medicine objectifies the body in relation to a mental health crisis has laid the foundation for interrogation of crisis and crisis intervention. Definitions of what a mental health crisis entails within the literature is next, followed by the notion of professional intervention and how services are constructed within a NZ policy context.

4.8   Defining crisis

Crisis has been defined in a variety of ways. Most authors suggest it is a certain point of change that involves a stressful event or experience that affects mental stability and results in a lack of ability to cope or even function (Aguilera, 1998; Hoff, 2009; James & Gilliland, 2013). A popular definition from Caplan, suggests people are in a state of crisis:

> …when they face an obstacle to important life goals-an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganization ensures, a period of upset, during which many abortive attempts at solution are made (1964, p.18)

In recognition for the need to change in a situation of crisis, Sarri suggests:

> [a] crisis arises from a traumatic event that is unpredictable and uncontrollable. There is an inability to influence it by one's actions. The nature of the event changes values and priorities, and indeed changes everything (2005, p.19).

A definition of an individual or system in crisis is by no means fixed or absolute and many definitions are worth considering including how crisis might be framed in a clinical sense. Roberts offers a comprehensive clinical definition of crisis as:

> An acute disruption of psychological homeostasis in which one's usual coping mechanisms fail and there exists evidence of distress and functional impairment. The subjective reaction to a stressful life experience that compromises the individual's stability and ability to cope or function. The main cause of crisis is an intensely stressful, traumatic, or hazardous event, but two other conditions are also necessary: (1) the individual's perception of the event as the cause of considerable upset and/or disruption; and (2) the individual's inability to resolve the disruption by previously used coping mechanisms. Crisis also refers to an upset in the steady state. It often has five components: of hazardous or traumatic event, a vulnerable or unbalanced state, a precipitating factor, an active crisis state based on the person's perception, and the resolution of crisis (2005, p.778).

As a result, the individual's mental health and, at times, social relationships may be seriously compromised or impaired (APA, 2000). Other authors suggest that crisis is a temporary state of disequilibrium or emotional upset (Aguilera, 1998) that is accompanied by confusion, disorientation to usual problem solving capabilities (Michenbaum, 2005) and is characterised by disorganised behaviour (Kleespies, 2009).

Two main conditions are deemed essential in the identification of crisis. Firstly, the perception that the crisis event will lead to considerable upset or disruption, and secondly, the person is seen to be unable to resolve the disruption with the available coping methods they can use (Larkin & Beautrais, 2010; Myer & Moore, 2004; Van der Kolk & McFarlane, 1996). Both developmental and situational theories of crisis suggest that the experience manifests in a person with a feeling of being out of kilter with their world. This commonly involves anxiety and mood swings, which produce a perception in the person that their life is in some way out of control and renders them, in other people's view, vulnerable and unpredictable (Palmier-Claus et al., 2013). The goal of crisis intervention is the return to the same or a higher level of social functioning experienced prior to the crisis (Anthony & Ashcroft, 2006).

4.9   What constitutes being in crisis as a situation requiring professional intervention?

Much of the literature concerning interventions for people in distress up until Caplan's publication of *An approach to community mental health services* (1961) and *Principles of preventative psychiatry* (1964), was in the domain of developmental and behavioural therapists or professionals within the psychiatric setting (Edward, 2005). A convergent model of crisis intervention represented an important change in therapeutic emphasis given its basis in mental health and adjustment rather than an orientation to psychopathology, as was apparent prior to the 1960s until it was subsumed again in the late 1980s (Wolbert Burgess & Baldwin, 1981).

Prior to publication of Caplan's papers on interventions useful in crisis management, people with problems concerning adjustment to life stress were treated in therapy-based practices, whilst those deemed mentally unwell or diagnosed with mental illness were treated in an institutional psychiatric setting. A convergent model of crisis intervention was developed in response to a series of scientific and social debates surrounding mental health service provision for people in distress (Roberts, 2005; Roberts & Ottens, 2005. Debate concerned the location of services (McLean, 2003), modes of treatment (Anthony, 1993) and social rights (Pilgrim, 2005) of people experiencing mental health problems during a time when the cost

associated with treatment for mental illness was a pursuit of social development reforms.

Since the 1980s, descriptions of people in crisis and those experiencing mental health problems have been a popular pursuit in the fields of research, film, television documentary and talk shows. This is in contrast to the historical *out of sight, out of mind* mentality that existed prior to a growth in the interest of reality oriented media that surfaced stories about being mentally unwell from the people who had experienced such phenomena (Lapsley et al., 2002). Additionally, in societies where medical discourses have come to occupy a privileged position, people experiencing mental health crisis are not seen as having expertise, their voices are subjugated (Busfield, 1996).

Historically, service user discourse has been regarded as unreliable, lacking rational sense and a denial of their voice within mental health literature has been apparent (Hui & Stickley, 2007). This lack of regard for service users discourse of every day coping is especially apparent for those people experiencing a mental health crisis (Edward, 2005; Veitch, 2007). In part, this is due to what Foucault (1977a; 1994) termed the *discourse of unreason*, where the need to discipline difference in people with the aim or producing normalised, docile and productive citizens becomes a silencing force.

Although mental health organisations have encouraged the participation and publication of service user experiences since the 1980s, some argue this has been in the most part a campaign to normalise mental illness (Hui & Stickley, 2007; Pilgrim, 2008). Accounts of crisis told by those who have first hand experience of mental distress bring about the opportunity to challenge the dominant discourses and institutional practices that exercise power over those involved in receiving and enacting services (Lakeman, McAndrew, MacGabhann & Warne, 2013).

4.10   The newly created field of crisis intervention in New Zealand

Studies of human responses to stressful or traumatic experiences and the economic cost of services needed for those in crisis increasingly became an area of focus for health professionals working in a mental health setting (Hoff, 2009). A multidisciplinary movement involving research and practice development gained

momentum during the 1980s and 1990s and led to a convergent model of crisis intervention. Mental health professionals accepted the convergent model as a treatment of choice for many people seeking help in a range of counseling and health services (Borrell-Carrio, Suchman & Epstein, 2004; Engel, 1977). Typologies of crisis and change theory are used in crisis intervention education and practice to understand particular populations of people in distress and are argued to be a *best practice* structure of deliberate brief interventions (Hoff, 2009). Such typologies (*see figure 1 for an example*) identify certain life events and issues that are thought to produce stress and vulnerability (Roberts, 1995).

Life issues such as parenthood, infertility, divorce, and child abuse; being a *victim of wrong doing* such as incest, rape, assault or other violation; as well as *natural* disasters like earthquakes, fires, and floods are arranged in a hierarchy and used to identify the likelihood of mental illness developing as a result of experiencing such life change (Loughran, 2011). Psychological life inventory scales were developed primarily by male psychology academics and their narrow focus on gender (Busfield, 1996; Ussher, 1991), heteronormativity and patriarchal life roles has been widely criticised (Herek, 2000; Lunbeck, 1994; Simoni & Walters, 2001).

Figure 1: The Holmes-Rahe Life Stress Inventory - 10 most risky life events

1. Death of spouse

2. Divorce

3. Marital Separation from mate

4. Detention in jail or other institution

5. Death of a close family member

6. Major personal injury or illness

7. Marriage

8. Being fired at work

9. Marital reconciliation with mate

10. Retirement from work

Source: Adapted from Thomas Holmes and Richard Rahe, (1967). Homes-Rahe Social Readjustment Rating Scale.

Life inventory scales and the convergent model of crisis intervention discussed in detail next are examples of what Foucault termed as grids of specification. Neville (2005) suggests Foucault's grid of specification is a systematic and constructive discursive ordering of concepts occurring within a discourse. Within the risk inventory frameworks the object of mental disorder in the biomedical discourse is outlined by its physical, psychological and situational states and presented as a score of risk and subsequent need for intervention. The object of mental disorder is formally utilised in crisis intervention by both psychiatrists and mental health nurses and emerges in the docile person seen as being in crisis. Holmes (2002) suggests classification systems and *best practice models* of standardised intervention for people experiencing a mental health crisis are jointly manipulated and collaborated through medicine and nursing. Furthermore, this manipulation occurs in the deployment of a dominant medical discourse, which positions the discourse as essential in shaping mental health nursing practice and the type of interventions offered to those in crisis.

Crisis intervention became a generic term from the late 1980s and encompassed a broad range of therapeutic practices targeted at human stress reactions to predictable and developmental life-crisis events (Aguilera, 1998; James & Gilliland, 2013). Today, crisis intervention is a feature of every contemporary mental health nursing text despite that it remains inconsistent (Lilienfeld, 2007; Loughran, 2011) and sometimes ineffective due to practitioners who are inadequately trained, yet required to use it (James & Gilliland, 2013; Lilienfeld, 2007; Rothschild, 2006). Adherence to a certain approach to crisis intervention and the potential for measureable outcomes is discussed further in the next chapter.

A convergent model of crisis intervention *(summarised in figure 2)* became the basis of a change process for most crisis intervention workers and was further strengthened by several other factors (Loughran, 2011; Peplau, 1997). The practice of crisis intervention has a variety of aims and objectives. Interventions aim to reduce the intensity of an individual's emotional (Egan, 2010; Mearns & Thorne, 2007), mental/physical (Aguilera, 1998) and cognitive/behavioural (James & Gilliland, 2013) reactions to a crisis. Another aim of the interventions and suggested outcome is to help individuals return to their level of functioning before the crisis (Egan, 2010; James & Gilliland, 2013). The person's level of distress can be

decreased and their functioning may be improved by development of new coping skills and reduction of ineffective ways of coping, such as withdrawal, isolation, and substance abuse (Roberts, 2005). As a result, people who experience crises are better equipped to cope with future developmental or situational difficulties or problems that may occur for them. The objective of resolving a crisis, through talking about what happened and expressing feelings associated with the event is to develop new ways of coping (Roberts & Ottens, 2005).   Crisis interventions are suggested to be most effective at the onset of crisis, or first episode of distress, to enable the person to recover from the crisis and to prevent serious long-term problems from developing (Myer & Conte, 2006).

Figure 2: Convergent model of crisis intervention:
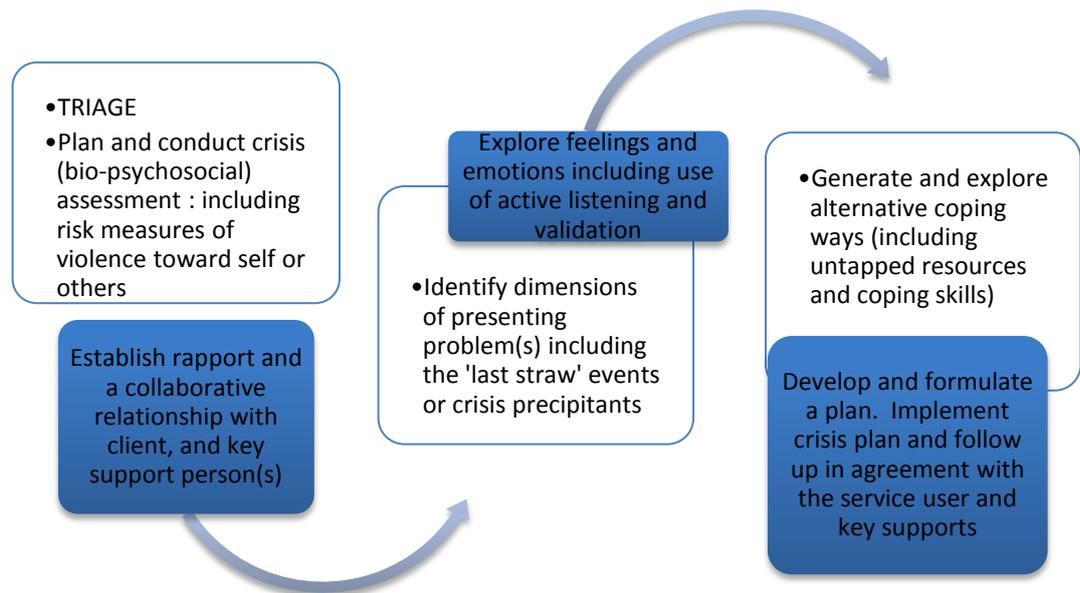
Source: Adapted from Roberts' seven-stage crisis intervention model. In Roberts and Ottens, (2005), Seven-stage crisis intervention model: a road map to goal attainment, problem solving and crisis resolution.

Despite widespread implementation of crisis intervention models within community mental health services during the 1980s, organised psychiatry continued to state that there was little evidence that the interventions located in the convergent model, made much of a difference to the outcome for people in crisis (Sayce, 1999). Medical questioning of non-biological treatments gained momentum alongside their public critique of service user inclusion in service planning (Gray, 2000).

Psychiatrists continued to describe consumer groups as ill-positioned to understand admission statistics, having little scientific foundation or evidence and poor understanding of the complexities involved in the assessment and treatment of mental disorder within a crisis situation (Katschnig, 2010).

Service user perspectives continue to be put forward in arguments to counter inaccurate information on the use of compulsory admission, risk management practices and overuse of psychopharmacology, which is growing internationally in use with children and adolescents (Watkins, 2007). The service user movement is equally critical of psychiatry's evidence and see themselves as unfairly stigmatised by pseudo-classification systems such as the DSM (Noorani, 2013). They argue that there is much change needed to counter the continued denial of their self-determination and crucial role in the reshaping and delivery of mental health services throughout the world (MHF, 2003; Tomes, 2006).

Mental health services, with crisis teams at their core, have changed over time (Edward, 2005). Assessment and treatment has become aligned with other health services such as outpatient physical treatment (Anthony & Ashcroft, 2006) and primary care (Dury & Munro, 2008) in a move to position services as an individualised and seemingly accessible or normal way to seek and receive appropriate intervention (WHO, 2008). People now make appointments at community mental health clinics and private therapy practices and routinely receive house calls for their *mental health needs* as a consequence of services becoming *citizen activated* and *user friendly* in choice (Busfield, 2010). However, who decides about the venue of when and where services are accessed and whether or not people experiencing distress want routine prescriptions for medicines and uncertain diagnosis, is debatable.

Coercion in psychiatry can be defined as any attempt to impose treatment against a patient's wishes (Rogers & Pilgrim, 2001). Mental health legislation permits treatment to be imposed on those diagnosed with mental disorder on the grounds of the health and/or safety of the patient or public (MHA, 1992). The lowest level of pressure is persuasion, in which the benefits and risks of treatment are debated but the patient's arguments are respected. A higher level of pressure may be exerted by using an interpersonal relationship between a clinician and a service user

to exert force by expressing disapproval with decision making or withdrawing access to services (McSherry & Wilson, 2011). Threats convey the intention to leave the person in crisis worse off if they don't comply. Furthermore, legal compulsion legitimises the use of physical force (Minkowitz, 2010).

The discussion in the next section is related to the implementation of crisis intervention within a NZ context. Following this I provide a brief overview of what is not being said about crisis intervention, which concludes this chapter. In line with the aim of discourse analysis it is important to reflect to the reader not only what is being said but also what is not said.

4.11   The implementation of crisis intervention within a New Zealand context

Crisis intervention services are contracted to support people whose mental health has deteriorated to such a degree that they need urgent specialist assessment and treatment or that they are a risk of harm to themselves or others (MHC, 2001). In 1996, Judge Mason headed an inquiry into acute mental health services and found that access was problematic and consultation with family and interagency communication was poor. Movement away from inpatient care and development of community mental health services resulted from the Mason Report (MHC, 1998; MoH, 1994) and this created considerable resource implications (O'Brien et al., 2007). Most service users now receive acute care from community mental health teams. However admission to inpatient treatment continues to be available within a range of services including crisis respite, early intervention and intensive mobile home based treatment that are accessed by crisis mental health teams.

Crisis assessment and treatment teams were established in NZ from the early 1990s as part of the NZ governments programme to deinstitutionalise mental health care. With the introduction of the Mental Health (Compulsory assessment and treatment) Act (1992), emphasis became on the *least possible restrictive environment* and crisis services played a significant role in building and supporting a network of community based mental health services. Crisis teams are primarily staffed by experienced registered nurses who specialise in mental health nursing (O'Hagan, 2006). The teams are multidisciplinary, of differing combinations throughout NZ but most include at least clinical consultation and liaison with psychiatrists, psychiatric

registrars, social workers and allied health professionals. Mental health nurses and allied health professionals work across three shifts in a 24-hour span, 7 days a week.

Crisis services provide for adults aged 18-64 years old from 8am to 4.30pm and after hours cover everyone including those under 18 and over 65, experiencing an acute episode of mental illness suggested to be at risk of harming themselves or others due to their mental condition (MoH, 2008c). Teams provide crisis assessment, intervention, home-based treatment and broker acute inpatient mental health beds for those who are not seen to be able to be treated sufficiently within a community setting. Crisis intervention usually results in one of the four following outcomes: 1) admission to an acute inpatient mental health unit either voluntarily or via the Mental Health Act (1992) process; 2) referral to a mainstream or Māori mental health community based services for follow up; 3) home based crisis treatment by clinicians within the crisis team; 4) no further action takes place with any referral and the crisis team closes the case or episode of care (Te Pou, 2011). Home-based treatment might mean crisis assessment and treatment takes place in the person's home or with a family member or within a crisis respite facility, which is staffed usually by mental health support workers and overseen by mental health nurses in the crisis team.

Whilst little has been published in NZ regarding crisis specific services over the last ten years, there has been considerable government literature generated in regard to provision and forward planning of community mental health and addiction services (MHC, 2007; 2012a; MoH, 2005; 2006c). According to the MHC report *Open all hours*? (2001), delivery of crisis services is varied and reflects the development of interventions in response to local population need; cultural requirements; differences between urban and rural communities, and service capacity. In summary, the report suggests crisis services in NZ have three common components:

1. To carry out triage and assessment of service user in the most acute or serious need. Some crisis services also offer short-term monitoring of medication and supportive treatment.
2. All after hours assessment and intervention is undertaken by crisis services, including adults, older adults, young people and children.
3. They are involved in compulsory processes defined under the MHA (1992) and subsequent amendments.

There are two distinct models of crisis delivery including standalone services and integrated services. Standalone services are distinct teams of crisis staff who focus on urgent assessment and crisis intervention. Integrated services are teams who take on all aspects of community mental health services including crisis intervention. Within the integrated model mental health nurses may be designated solely as crisis workers or have a mixed role of crisis intervention and case management including ongoing relationships with service users (MoH, 2012a).

4.12   Governmental implementation of social regulations regarding risk

Power within institutions and society is seen as all pervading and permeates every interaction between people in their relationships (Foucault, 1980b). Perron et al., (2005) argue that mental health 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, nurses promote compliance behaviours in service users by monitoring and surveillance of biological diagnostics and treatments (Lakeman, 2013). Furthermore, mechanisms of control and coercion directed at service users that the public do not dispute, are seen as gains toward healthy behaviour and self-management (Wand, 2013).

Foucault termed the promotion of compliance behaviour through monitoring and health education as *bio-power* (Gestaldo, 1997). Bio-power is sanctioned in documents such as *Guidelines for Duly Authorised Officers* (MoH, 2000b; 2012) and *The Risk Toolkit* (MHWDF, 2006). According to the MoH (2000b; 2012) under Section 130(a) of the MHA (1992), the Director-General of Health may from time to time issue guidelines for the purposes of the Act. DAO guidelines, recently updated in 2012, are intended to provide some guidance, interpretation and practical application as to the role and function of DAO's. Many of the mental health guidelines have been written due to the findings of the Law Commission's report on an *Inquiry under Section 47 of the Health and Disability Services Act (1993) in Respect of Certain Mental Health Services* (Mason, 1996).

In 1998, the Ministry of Health published *Guidelines for risk assessment and management in mental health services.* In her introduction to the guidelines, the then Director of Mental Health Janice Wilson states:

A frequent finding in inquiries into failures of mental health services, both here and overseas, is a lack of robust risk assessment and management. The language of *risk* has become the predominant discourse, not just in clinical practice but across an increasingly wide range of government and private activities, and dealing with both the 'hazards' and the 'outrage' is an increasing necessity (1998, p. iii).

The guidelines for risk are a key strategy within a discourse of accountability and the technologies used by mental health services, particularly crisis teams, include a raft of interviewing schedules and communication requirements.

An accountability discourse is written at the beginning of the document that signals to the reader the purpose and expectations of use:

These guidelines are written to provide a basic framework to guide and aid mental health clinicians to better assess and manage clinical risk. They cover all mental health settings and disciplines, not just acute inpatient or forensic settings, and are equally relevant to crisis teams and community-based services (1998, p.1).

The publication of risk guidelines was an important strategy used by the Ministry of Health, primarily as an attempt to address the findings of the Mason Report (Mason, 1996) and it signaled new lines of accountability in the changing context of mental health service delivery. Implementation of risk management and how an accountability discourse has developed within crisis services is discussed alongside data from the participants in the following data chapters.

In 2006, the Mental Health Workforce Development Foundation (MHWDF) published *the risk toolkit*. The risk toolkit is a workforce training technology that built on the risk guidelines (MoH, 1998). The aim of the 2006 document is to provide guidance to clinicians working with service users who have a previous history of violence toward others (MHWDF, 2005). However, the document states:

…risk is a broad concept and can include risk to self, risk of financial or sexual exploitation, risk of relapse, risk to property and so on. The principles of risk assessment and management presented in this workbook are likely to be conceptually relevant for other aspects of risk (MHWDF, 2006, p.3).

The risk toolkit is a technology explaining to the reader how to recognise the potential for violence from a mental health patient. Without reference to literature the document lays out normative inventories of personal circumstance to look for in assessment (*see figure 3)*. The checklist states: "static risk factors for violence are those factors that either do not change over time or are relatively stable" (MHWDF,

2006, p.9).

Figure 3: Checklist inventory

1.   Male gender.
2.   Age.
3.   Childhood maladjustment and behavioural problems.
4.   Childhood abuse.
5.   Lack of educational achievement/truancy.
6.   Employment problems.
7.   Previous pattern of violence and aggressive behaviour.
8.   Young age at first violence.
9.   Previous incarceration.
10.   Personality disorder e.g. psychopathic, narcissism.

Source: Mental Health Workforce Development Foundation (MHWDF) (2006).

Foucault argued that objectifying the patient or the *clinical gaze* developed from the Age of Enlightenment (Holmes, 2001). Within the clinical gaze is the notion that trained experts are in a position of *knowing better* than the person directly experiencing distress (Crowe & Carlyle, 2003). The intention of risk guidelines following the Mason Report, was to provide standardised reporting of incidents and education and training to improve access to services and communication with users of services (MoH, 1998). Instead however, they are used by the DHB and external monitoring agencies such as the Health and Disability Commission to ascertain if mental health services are documenting their role of assessment and monitoring of people with mental disorder and associated risk (Mullen, Admiraal, & Trevena, 2008; Te Pou, 2012). Risk assessment and the use of normative judgments by participants, is a key point of discussion in the next chapter of this thesis.

A direct consequence of mental health policy is the dismantling of institutional mental health care to a community or *in situ* oriented regime of interventions and practices. In the past, *the clinical gaze* would have been recognised in the hospital setting and people would have in the most part kept their homes and home-life private. However, since the closure of all large psychiatric institutions during the 1980s and 1990s in NZ, there is now a move away from objectification of psychiatric patients, to subjectification of service users where crisis staff measure the potential risk associated with normative inventories (Cutcliffe, Stevenson & Lakeman, 2013). Surveillance of clinical staff too, as Mullen et al., (2008) warn, is a direct result of a risk aversion culture developing and secondly, the proliferation of

treatment protocols and guidelines may make practitioners reluctant to trust their own judgment.

There has been a considerable shift in how urgent mental health services within NZ are organised and delivered. As a result people experience crisis assessment and intervention in their own home or within a community setting (Sawyer, 2008). Mental health nurses make up a significant proportion of the crisis intervention workforce. Crisis nurses have a legal mandate under the MHA (1992), to act as a gatekeeper for mental health services and the community and to work with a group of people who have the most urgent and acute mental health needs.

The MHA (1992) changed the way that people experiencing mental distress access services or are seen for assessment and potential treatment on a compulsory basis (Diesfeld & McKenna, 2006; McKenna et al, 2009). According to the MoH (2012c), at any given time, 60 people per 100,000 are under compulsory community treatment orders whilst others are detained in hospital. 17 people per 100,000 are subject to an inpatient treatment order, with 5 people per 100,000 subject to inpatient orders, but on leave. Since the introduction of the MHA, there have been several amendments made to the legislation such as the Mental Health Compulsory Assessment and Treatment Amendment Act (1999) and redevelopment of crisis intervention services have resulted. These changes have consequences for service users, families and nurses relating to how the interpretation of mental disorder is viewed in a crisis and who is responsible for safety and communication during the process of assessment and subsequent treatment or discharge.

Within NZ and other Western countries crisis mental health services are crucial to the delivery of mental health services that play a vital and valuable role in the provision and support of District Health Boards (DHB), Non-government organisations (NGO) and Primary Health care Organisations (PHO) (MoH, 2005; 2008a). Strategies such as the MHA (1992) and community care have developed many technologies for example the DAO guidelines and risk assessment tools.

Crisis is a normal part of life, so too is families and communities caring for people experiencing crisis. In an ideal world, people acquire help before they begin to experience a crisis situation. However in reality, discrimination toward people

experiencing mental distress and illness (MHC, 2001; 2001a; O'Hagan, 2006; Peterson, Barnes & Duncan, 2008), alongside inadequate funding of preventative intervention for people in crisis (Lyons, Hopley & Horrocks, 2009; Walsh, Stevenson, Cutcliffe & Zinck, 2008), result in barriers to people getting the right kind of help when they need it.

4.13 Summary

This historical literary review of crisis intervention has focused analysis on the power effects of knowledge, particularly the discourses of scientific knowledge taken up by professionals in the field. In doing so, discussion can open up the potential for strategies of resistance and change. In this history of crisis intervention becoming an event in mental health services, a shift in power caused by the dispute between psychoanalytical and biological psychiatry converged to create a new biopsychosocial approach to crisis service delivery. Mental health survivor discourses appeared to be legitimised by a biopsychosocial approach. But, within a context of post liberal welfare reforms a biopsychosocial approach was subsumed again into a biomedical discourse.

Despite this being challenged through ongoing lobbying from the survivor movement and family activist organisations, crisis intervention services remained firmly in the realm of medically led mental health services. Mobile risk orientated crisis intervention services that developed primarily in the United States during the 1970s and 1980s, were rapidly set up in the UK, then Australia and NZ.

In the late 1980s NZ community mental health services developed in a context of changing strategies such as legislation and mental health policy reform. In order to provide access to community services, crisis intervention teams were set up as part of the government response to deinstitutionalisation to provide a point of entry to all mental health services. Strategies and technologies influencing crisis intervention and rationalisation of crisis services will be discussed in detail within the next chapter.

Discussion of specific mental health policy and law that drives practice and informs the roles and responsibilities of clinicians in a NZ field of crisis intervention is further presented in the next chapter. Alongside the policy and practice guidelines,

analysis of participant data highlights how those involved are constituted as subjects of specific forms of knowledge.

In the next chapter I consider the notion of mental illness *taking hold* of people experiencing distress and how strategies such as psychiatric diagnoses and technologies such as mental health outcome measurements contribute to an accountability discourse associated with the discursive construction of risk management and mental disorder. Chapter five entitled *Rhetoric of holistic nursing* includes discussion on the NZ Mental Health Compulsory Assessment and Treatment Act (MHA), (1992) with a focus on the roles and responsibilities of those involved in the discursive practice of being labeled *at risk*. Data from the participants is presented to problematise mental disorder and risk management within crisis intervention and to surface whose voice speaks loudest and who is silenced in the field. This discussion highlights an unintentional divergence in law and mental health policy.

Chapter five: Rhetoric of holistic nursing in a mental health crisis

5.0   Introduction

In the previous chapter I presented a historical literary review of crisis intervention within a Western mental health service context. Following the discussion about the move to community mental health influenced by the antipsychiatry and mental health survivor movements, the dominant biomedical discourse underpinning crisis intervention was critiqued with the aim to disrupt the notion that crisis intervention can be viewed as a fixed, stable or dependable entity. A tension has developed into an uncomfortable coexistence between medicalisation and normalisation within crisis intervention and this is the context in which this chapter begins analysis of the perspective of the participants involved in this study.

This chapter includes analysis of mental health risk management policy and legislation that unnecessarily marginalises service users and families, but also the nurses involved in this study. Data from each of the participant groups is presented to reconsider the strategies and technologies involved within discourses surrounding crisis intervention. In particular technologies of risk assessment, diagnosis and outcome measurement tools are critiqued. Risk management and the therapeutic relationship exercise surveillance in crisis intervention. Through risk technologies, fear and threat have a disciplining effect between nurses and services users.

Since the introduction of the MHA (1992), there have been several amendments made to the legislation and redevelopment of crisis mental health services as a result. These changes have consequences to service users, families and mental health nurses relating to how the interpretation of mental disorder is viewed in a crisis situation and who is responsible for safety and communication during the process of assessment and subsequent treatment or discharge. There is little evidence in the literature about how the changes to the legislation have impacted on policy and the practice of crisis work or how mental health nurses have adapted to their broadening approach to crisis work given the social and organisational changes happening within society.

5.1 Whose voice speaks the loudest and who is silenced in the field

Until the advent of a report authored by Judge Ken Mason (Mason, 1996) who stated that the provision of mental health care in NZ was inadequate and problematic, little had been published in regard to the state of crisis intervention services. Whilst there was a momentum towards providing mobile urgent services within the community, evaluation of the impact of the deinstitutionalisation process and considerable resource implications were not yet apparent within published literature or policy (O'Brien et al., 2007). After the review by Mason, the NZ government established the Mental Health Commission (MHC) in 1996 and invested significantly in service provision and workforce development (MHC, 1998; MoH, 2000a).

The original mandate of the MHC was to establish national advocacy, monitoring and development of research and practice within the mental health sector (Mason, 1996; MHC, 1998). The MHC promoted a variety of publications regarding recovery-orientated practice (Mental Health Advocacy Coalition, 2008), social inclusion (MHC, 2001, 2011) and the promotion of the rights and responsibilities of mental health workers (MHC, 2008a), rights of service users (MHC, 2005a; 2008b) and their families (MHC, 2003). In 2012 the Crown Entities Reform Act disestablished the Mental Health Commission and the organisation's last publication was Blueprint II (MHC, 2012a/b). Consequently, advocacy and monitoring functions in the mental health and addictions sector were transferred to the Health and Disability Commissioner. In addition, a new position of Mental Health Commissioner was established within the Office of the Health and Disability Commissioner.

Mental health policy documents are used within analysis of this and subsequent chapters to interrogate the social development discourse of policy and the discursive construction of expertise in practice. The aim to include mental health policy at this point in the thesis is to consider discursive practices that influence social relations affecting the operation of crisis intervention services. Mental health policy can include promotion, prevention, treatment, rehabilitation and advocacy (WHO, 2008). A definition of mental health policy from the WHO is:

A policy is a specifically written document of a government Ministry of

Health containing the goals for improving the mental health situation of the country, the priorities among those goals and the main directions for attaining them (2001, p.1).

Beginning with the identification of an issue, policy develops once the problem, for example, access to services or quality and appropriateness of care, is identified (Lester & Glasby, 2006). During the proposal period of policy development, complex political decision-making processes occur. This includes power, cost, potential impact and vested interests, all of which affect the outcome (Whiteford, 2005).

Mental disorders rank fourth of the ten leading causes of disability in the world and are projected to be second by 2020 (WHO, 2001; 2007; 2013). Interestingly, mental health is not included within the eight Millennium Development Goals (WHO, 2005), which set targets for both developed and developing countries in regard to improving human conditions of hunger, illness, poverty, education, gender inequality and environment (WHO, 2010). Exclusion of mental health from these global health policies infers that mental health may be viewed as less important than physical illness such as HIV/AIDS, malaria and maternal health, all of which are health targets in the millennium goals (WHO, 2013).

Statistically, mental disorder is measured currently as 12% of the total disease burden in the world and likely to be at 15% by 2020 (WHO, 2001; 2007; 2013). These numbers are impressive, given that one in four people will experience a significant mental health problem in their lifetime, and globally at any one time 450 million people experience an episode of mental illness, most of whom do not receive treatment (WHO, 2013). From an international perspective, mental health services tend to have a low priority on the public health agenda and this has significant policy, budget and service implications (Khandelwai et al., 2010). Furthermore, Garfield, Samuel, Zuvekas, Lave and Donohue (2011) suggest that all too often, mental health needs must compete with physical health needs in order to appropriate adequate resources for mental health service users.

From a NZ perspective the Mental Health Foundation (MHF) propose:

Government-sanctioned measures of mental health at a population level in New Zealand almost exclusively focus on levels of mental illness (i.e. rates of diagnosis for specific conditions); for instance, Te Rau Hinengaro and the mental health section of the New Zealand National Health Survey. This is a reflection of the common use of the term 'mental health' to refer to mental illness (MHF, 2010), even though the World Health Organisation (WHO, 2011) defines mental health as a positive state of being and functioning (2011, p.2).

The government literature interrogated within this study is regarded as bodies of text. The text has recurring language and dominant themes, which have been coded and grouped. Parker (1992) suggests discourse should be examined for connotations, allusions and implications and the interplay of text in relation to the broader system of knowledge. The text is used in order to critically re-explore the subject positions of the participant groups who engaged with me in this project.

The following discussion is intended to contribute to the need to consider "what was being said in what was said" (Foucault, 1990, p. 30) in mental health crisis intervention policy documents. Hui and Stickley, (2007) suggest there is a paradox evident when asking such a question, in that an individual must "have their own unique discourse to be able to compare and contrast with that of another" (p.418). In the process of examining potentially polemic discourses, alternative meanings can be revealed, even from the use of similar words. This provides an opportunity to (re)consider the relationships, associations and disassociations within the social reality of crisis intervention and mental health practice.

5.2 Governmentality of mental health policy

The NZ government mental health strategy began with two plans to guide mental health services during the establishment of community based services (MoH, 1994; 1997). Following this, the MHC publication of the *Blueprint* (1998) stated that services were to be delivered in the least restrictive environment with the least coercion and with an increased variety of home based treatments (MHC, 1998). Broad changes to the mental health workforce have been directed from these policy developments (MoH, 2005; 2010; Te Pou, 2009), including increase in access, amount and type of services provided alongside a reorientation of the knowledge and

skills from instutional to community oriented interventions expected from those employed within (MoH, 2008b).

The Blueprint (1998) document outlined several principles, for example, recovery being a personal and social process intended to underpin the new post-institutional values base for furture mental health services. Principles within Blueprint (MHC, 1998) were later developed in policies such as, *Our lives in 2014: a recovery vision from people with experience of mental illness, for the second mental health plan, and the development of the health and social sectors* (MHC, 2004); *Te Tahuhu: Improving mental health services 2005-2015* (MoH, 2005); and *Te Kōkiri: the mental health and addiction action plan 2006-2015* (MoH, 2006a). These policy documents outline the need for a wide range of services which:

- Are based on good evidence and are provided in the least restrictive environment;
- Enable people to lead their own recovery;
- Balance biological, psychological and social factors; and
- Are responsive to all cultures and age groups and recognise whānaū ora (MoH, 2005; 2006a)

Mental health crisis teams operate within the same broad legislative, organisational, strategic and funding frameworks as all other mental health services. However, as Chaplow, longstanding Director of NZ Mental Health Services, in MoH (2008c, p.4) points out, the things that make mental health different are:

- Statutory permission for compulsory treatment
- The Mental Health Commission
- The cross-directorate responsibilities within the Ministry and the sector
- The number of non-governmental organisations involved in service delivery
- The Blueprint funding stream (MHC, 1998)

The agenda of mental health policy since the Blueprint (MHC, 1998), was concerned with actions of quality improvement and outcomes of self-government for those using and working within services over the next decade (*see figure 4*).

Figure 4: Agenda for Action*:*

1. Promotion and prevention
2. Building mental health services
3. Responsiveness
4. Workforce and a culture of diversity
5. Māori mental health
6. Primary health care

7. Addiction
8. Funding mechanisms for recovery
9. Transparency and trust
10. Working together

Source: Te Tahuhu: Improving mental health services 2005-2015 (MoH, 2005)

The ten key agenda items, which are broad aims, have developed from a decade of mental health service reforms. They are an example of the move toward institutional inscription where an expanded horizon of expectations and a calculating outlook toward naturally arising uncertainties is planned. However workers within services make choices about how they go about the actions required to enact the policy vision and are not required to instigate them. In contrast, the institutional inscription ascribed through mental health law requires services to undertake crisis work in a *least restrictive environment* (MHA, 1992).

Institutional inscription has resulted from a complex web of changing perceptions about people with mental illness. In particular, the notion of how people in crisis may impinge on the rights of others (Bell & Brookbanks, 1998; McSherry & Wilson, 2011) related to the risk they pose, due to self harm or diminshed capacity to care for themselves or their potential to harm others due to the service's assessment of them being *mentally disordered* (MHA, 1992). The compulsory mandate is publicised though *bad press* about people with mental illness, which has also strengthened the historical discourse of dangerousness associated with people who are distressed or experiencing psychiatric symptoms (MHC, 2005; MHF, 2003). The discourse of madness (Busfield, 1996; Foucault, 1988) has evolved over time, from one where clear links to social exclusion, control and incarceration in madhouses, asylums, prisons has more recently relocated to control through assertive outreach teams and acute units within general hospitals (Cutcliffe et al, 2013). This control and compulsion element of discourse remains alongside another discourse of madness of how an object of mental disorder might be understood and responded to from a societal perspective. Both discourses have developed alongside each other within mental health policy.

Mental health policy is orientated around discursive constructions of

particular problems or needs (Barnes & Prior, 2009). In the next section of this chapter I demonstrate through analysis of participant data that distinctive policies and practices are realised materially through strategies and technologies shaping and constraining the context of practice and ultimately, the experiences of the participants.

5.3   Whose problem is the problem of mental disorder?

In the previous section I discussed the policy context in which crisis services are provided. Policy has been reformed in conjunction with implementation and amendments to the NZ Mental Health (Compulsory Assessment and Treatment) Act (1992) (MHA). Acute and crisis services existed prior to the MHA, however with its introduction new roles and responsibilities for mental health nurses occurred. As previously noted the most evident role written within the MHA legislation and practice guidelines designated to mental health nurses is that of the Duly Authorised Officer (DAO).

The MHA had several amendments between 1999 and 2003. In 1999, Parliament passed the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999 (1999 Amendment), which came into force on 1 April 2000 with new guidelines (MoH, 2012). The guidelines outline the DAO role as the provision of expert information and advice on the mental health needs and services that may be required by people who are experiencing mental health difficulties and, "where appropriate, to facilitate the assessment of a person or proposed patient" (MoH, 2000, p.7). The Act stipulates what DAO's must do when carrying out their duties amongst other practices and procedures to form a regulatory legal framework.

Each DHB is required to have availability of DAOs and this has affected the configuration (MoH, 2000b) and more recently the responsiveness of crisis services in some areas (MoH, 2012; 2012a). The following quote is about a view of open access that is in this participant's view not sustainable. During the interview with Barry, a crisis intervention mental health nurse (MHN) since the 1990s, we discussed the effect of the designated role of DAO within crisis services.

MHN Barry stated: *"People now would prefer to access services through the crisis team, it's the one door that never closes. All you have to do is change the language in the conversation, you can change not very well to suicidal and suddenly that's the oil and the gears and the wheels start spinning really quickly. We see it with GPs, they use the word suicidal when in fact somebody isn't suicidal, they've got thoughts about not wanting to be here or they are in emotional discomfort as opposed to desperation...contemplating life doesn't mean planning death. And I think families do too, they soon learn the lingo as do service users about what's a level of tolerance I guess...one of the things with this DAO role thing that's been talked about is that 'any door will be the right door'* (p.8).

Whilst Barry suggests responsiveness is a good thing in that people would be able to get access to mental health services as they need them, he is suggesting that services are inaccessible and that people wanting access have to escalate the situation to get any intervention.

Another significant role designated within the MHA (1992) is that of the Responsible Clinician (RC). The MHA (1992) states a requirement that a leading mental health professional undertake final assessment and diagnosis in line with the DSM in order to establish mental disorder and dangerousness. Mental health nurses appear to have been reluctant to take up the role of RC within crisis teams with psychiatrists most often in the RC role.   Biomedical discourse previously discussed in chapter four provides for psychiatrists to take up responsibilities of problem identification through strategies such as the DSM V; and this is endorsed further in the MHA via their designated role of decision maker and clinical leader of service delivery. However nurses have an associated key hierarchical relationship with the RC and within crisis services to undertake the role and responsibilities of a DAO (NZCMHN, 2012; Street & Walsh, 1994) and increasingly that of the second health professional designated under the MHA (1992), (McKenna, Simpson & Coverdale, 2006; McKenna et al., 2009; O'Brien & Kar, 2006).

The MHA prescribes inherent responsibilities in the roles specified in legislation 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 experiencing a mental health crisis. 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 mental health nurses working in crisis services.

During our discussion on knowledge and skills required to undertake crisis risk assessment Andy, an experienced Mental Health Nurse employed in a rural crisis service, proposed terms such as *units* or *jobs* as a common descriptor for people trying to access services. The people accessing services experience a form of dehumanising from the nursing participants. The difference in perception of a crisis and expectations from the public was a concern for each of the crisis nurses in this study and is summarised by MHN Andy here:

> *"The public perception? It's somebody's got problems that are causing them emotional distress or they need to see a counsellor, but we are about acute jobs and the crisis worker, quite often the crisis worker is the wrong person to be seeing people with just emotional problems, I don't know, say relationship problems. It always intrigues me that someone who loses a partner after say 40 or 50 years, and they say 'well that person needs to see a crisis worker', it's the wrong person to be seeing. The big thing that I always found is that different people perceive what is a crisis and ironically, I think quite a lot of crisis workers too, that's why they very quickly become adept to recognising what is, what's not, what shouldn't be in the system and what should be channelled off somewhere else?"* (p.1).

Crisis nurses are required to assess people using the criteria of the Act which includes identification of mental disorder as well as the potential for harm according to the MHA (1992). 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 crisis nurses are able to implement the Act.

Deviations or abnormalities in the operation of how people think, feel and respond, are defined by medicine and supported by psychology through a biomedical discourse (O'Brien, 1999). MHN Andy's perspective highlights the example of normalising grief for someone who has lost a life-long partner coming into conflict with the medicalisation of mental disorder. The tension he perceives is

between attending to the needs of an individual during a process of grieving 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 (Akerstrom Anderson, 2003).

In the data extracts above, the purpose of crisis services is viewed differently by nurses, the public 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, p.52).

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

> *"We get a call from the public so we go down and get the person, take them into custody and it looks like they have some kind of mental health issue so we bring them back here [police cells] and get the DAO to assess them. Or otherwise someone calls us and says 'my son is going nuts' so 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"* (p.1).

Sergeant A spoke about people in crisis in a similar way to nurse Andy, likening the person in crises experience to a unit of service requirement or a job waiting to be dealt with. However Inspector B noted there are clear processes to be followed when the police are asked by the public to attend to someone suspected to have a mental health problem. Inspector A is a senior police officer primarily responsible for leadership and administrative duties within a regional role. Inspector A stated:

> *"Let's say we have a 21 code* [police call out to suspected person with mental disorder] *someone has rung and said I've got a concern about X or Y, and we think this person is going to self harm or they are threatening a family member...so we go and that attendance is sometimes enough – a K1* [police attendance resolved issue]. *Those cases stay in comms* [communication centre records] *for 3 months after that we drop it but we do put a lot of people through the charge system downstairs for prevention of suicide. It's tricky because we call the DAO as a precaution...sometimes though the person is intoxicated, they are impaired and it would be easy to solicit answers that indicate they* [the person in custody] *fit the Act* [Mental Health Act]*"* (p.2).

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, Turner & Kasper, 2011; Watson, Corrigan & Ottati, 2004).

Mental disorder cannot be associated with a person without reference to "a statistically constructed *normal case*" (Allan, 2012, p.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 (Bell & Brookbanks, 1998). According to Allan, impairment of the mind, "like disability, is not something missing, not a lack or absence its something added, an unasked-for supplement contributed by disciplinary knowledge and power" (2012, p.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, p. 215). The kind of power Foucault is suggesting developed in the eighteenth and nineteenth centuries within schools, prisons and hospitals. Foucault suggested the argument of "omni-discipline" in regard to prisons (Foucault, 1977a, p.235) where exhaustive disciplinary apparatus were developed to "assume responsibility for all aspects of the individual, his physical training, his aptitude to work, his everyday conduct, his moral attitude, his state of mind" (p.236). In our discussion Carl, an experienced MHN working in a large urban crisis service, described such omni-discipline he assumed was necessary in his role as a crisis worker.

> MHN Carl stated: "*You have these kinds of crisis or blow ups if you like, and people have to learn how to deal with it, how to respond. You will have crises wherever there are people and it's our job to determine the level of disorder, assess the risk to self or others then put the measures in place to deal with it…our role is to be frontline access and deal with situations where the person is a risk to themselves or others because of their condition* (p.3-4).

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 & Holmes, 2008).

As well as defining discipline as a type of power, Foucault suggested, "discipline produces subjected and practiced bodies, docile bodies" (1977, p.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. Chas had been seen by an urban crisis team and later accessed services from within his local rural

community, 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?"* (p. 5).

Further, Foucault suggests, "discipline makes individuals; it is the specific technique of power that regards individuals both as objects and instruments of its exercise" (1977, p. 227). This account of people being the objects of various techniques and practices strengthens Foucault's account of power. Power involves the production of identity and action and results as the people in crisis are not only the objects of various techniques, for example, documentation, mental state examinations and behavioural correction techniques, but also subjects in the workings of disciplinary apparatus (Evans, 2010).

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. He stated that the subject is a form not primarily or always identical to itself. Furthermore, understanding Foucault's notion of the subject involves recognition between two different but interrelated meanings attributed to the subject.

Firstly, in the case of Chas, as service user, 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 of Foucault's subject is the subjective identity, that 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 the subjective identity of the subject in crisis intervention is extended to family members also. The expectation is that family members enact the discipline by adopting the strategies offered by the discipline as a support mechanism for their family. In the quote below, family member 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?"* (p. 8).

Foucault's notion of power in relation to nursing is outlined below. Pam, an experienced MHN working in a large urban crisis team describes the tension between normalising and pathologising people who access crisis services, she stated:

> *"Oh it frustrates me so much that people use the crisis team as a threat. I get really frustrated that relatives use us as a threat as well. In part, I suppose that's a cultural thing isn't it really, and the CAT* [Crisis Assessment Team] *team use it as a threat, and the police use it, I know they do. Sometimes I'll be talking with someone who is spinning out after a distressing life event and I think…I don't want to be here, I'm wondering why I'm here… and then you put it altogether and you realise that the person is being told by all those around then, if you don't behave we'll get the CAT team and we are seen as 'oh the mental health team can sort it, you know we've got this huge power"* (p.4).

From Pam's perspective, nurses working in crisis services have *huge power* and people refer to them when they have run out of patience with a person and want them *to behave*. The technology of *case management* requires nurses to install an obligation of self-management to the person accessing service. However, Pam identifies this is an issue as she could be doing more if given a chance at a therapeutic engagement. 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.

As outlined in the previous chapter, the changes to service configuration (MHC, 2007; MHC, 2012a) and demand for differing practice orientation of MHNs working in crisis teams has occurred over a period of time (O'Hagan, 2006). Since the late 1990s, mental health policies emphasised service user autonomy and action (MHC, 2012a/b). Although policies and legislation shape professional interventions

with an aim to be to be recovery focused in order to be ethical, a potential consequence of policy change has meant a shift to an individualisation of risk. Implementation in practices has meant that service users of crisis teams (and other mental health 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 mental health legislation and policy and is the topic of the next discussion.

5.4   The problem of risk

Mental health crisis intervention practice has become increasingly focused on the assessment and management of risk to and posed by mental health service users (Szmukler & Rose, 2013). Deinstitutionalisation and the uptake of community based mental health 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 & 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.

A changing landscape of service specifications and growth in community based mental health interventions, subjects mental health nurses, other professionals and support staff to new risks within their working roles (Rosenberg & Rosenberg, 2013). In my discussion with MHN Pam, multiple potential hazards for those accessing services and her own professional practice within the community setting concerned her deeply.

 MHN Pam 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 and we deal with situations like crisis respite being full, backed up calls to go to so we can't get to the police or ED. Then people start sending in complaints and our Team Leader spends hours dealing with things because we are so late. Oh the amount of time spent on paperwork as well…no wonder people have the*

perception that we are not available. But it does take time to deal with people in the community, much easier to put them in hospital or send them off with a script [prescription for psychiatric medications] *and loads quicker for us, but if anything goes wrong who does everyone blame? The crisis team of course"* (p.5).

Crisis service changes include a higher level of need, acuity and complexity among the people who access services, exacerbated by reduced inpatient care and early discharge practices (Chaplow, 2011; O'Brien et al., 2007). Most interventions that people access from crisis teams take place in their own home and as a result of work within these unregulated sites there are more potential hazards compared with institutionally based environments (Abas Vanderpyl, Robinson & Crampton, 2003; Bowers, 2005; Rosenberg & Rosenberg, 2013; Warner, 2006). Thus, the management of risk has become increasingly pivotal to crisis mental health assessment, intervention, documentation and interaction with people accessing services.

A common strategy is the risk screening/assessment model and the problem-solving approach that are widely utilised by a range of clinicians and seen to be of benefit of service users (Baldwin, 1977; 1980; Silverman, 1977). In a biomedical discourse, while doctors had a strong hold on both psychotherapeutic and pharmacological therapies, other mental health professionals, could be trained in crisis assessment and brief therapies to free up waiting lists for psychiatric clinics, reduce the need for hospitalisation and contain service users with medication to subdue the crisis before mental illness *took hold* (Callahan, 2000).

Crisis intervention gained new status within mental health services and the mechanism used to keep it there were under the control of psychiatry and its closest allies – pharmaceutical agencies and the law (Boyle, 2002; Moynihan & Cassels, 2006; Nasser, 1995). The *market* for preventative psychiatry established through crisis intervention services (Caplin, 1964) positioned doctors as the ongoing leader of cost effective treatment options. And they teamed up with psycho-pharmaceutical researchers and policy makers (Burston, 2012) to work in with newly establishing mental health legislation and funding policies of the 1990s and beyond.

The growth of medical-psychiatric and pharmaceutical industries within community mental health services since the 1990s is widely documented (Kutchins & Kirk, 1986; Saleeby, 2005; Wakefield, 1992; Wand, 2013). Saleebey (2005) suggests such an alliance between psychiatry and the pharmaceutical industry constitutes now, a type of *cartel* in that they are together "a group of institutions that control a particular market or social sector though a melding of their interests and exercising of their social power" (p. 23). Institutional knowledge/power is suggested by Foucault (1991a) as a means in which institutions control the fate of people who are deemed to meet the needs of their industry products. 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).

During the interview with Vicky, a MHN for two years and newly appointed to a large urban crisis service, I discussed what is most influential to her as a new practitioner to crisis work, in how she is learning her role. Vicky points out in the following quote that she believes all people who access crisis services have a right to decide how to live their lives but finds the medicalisation of people in crisis leads often to nursing defaulting to medicine and control.

> MHN Vicky stated*: "I think it's a very interesting issue the idea of freedom and choice in regard to people's life and death, I mean there's no other place in our health service where you'd be compelled to take all advice anywhere really, everybody else has to consent you know. With different kinds of disorders people can still decide for themselves what might be right in the long run. Trouble is the doctors and their constant need to give a script out every time they see someone starts to create expectations. I think as nurses we don't always consider much our feelings about that, it drives our responses with people as well, particularly when they are in crisis…you know, the idea that crisis is really opportunity rather than a problem and that crisis intervention is really about using energy around the potential for change really and yet we have a lot of services in NZ which are about containment and care – give them a label and a script and send them on their way. So the actual energy around a crisis is never kind of productive for people and partly I think that's about how*

we ourselves make judgments on what we think people should be doing" (p.7-8).

An aim of the medical/pharmaceutical alliance was to shift funding from a social model of crisis and interventions to the medical notion of mental disorder (Godrej, 2012). On the other hand, Crowe and Carlyle caution that the mental health nursing profession "carefully examine its socially mandated role as guardians of those who pose a risk to others and ensure that its practice represents its espoused therapeutic responsibilities" (2003, p.26).

Strategies within the biomedical discourse such as the use of the DSM (APA, 2000) for diagnostic categorisation and a variety of government endorsed technologies such as mental health quality outcome measures work together to sustain a truth that crisis services are experts on the object of crisis. The DSM is recognised as the most authoritative classification system of mental health disorders throughout the world and whilst it is the preferred means to allocate funding for mental health care within NZ, it is criticised widely (Crowe, 2006). What is considered to be a mental health crisis is not defined within the DSM; however, the classification system is used to formally recognise categories of mental disorder and the identification of a specific psychiatric diagnosis through the process of triage and crisis assessment. As MHN Pam pointed out:

> *"It's hard when the relatives say they* [service user] *should be in hospital. I want to say to them what do you think hospital will provide and I try and put them off, I try and normalise as opposed to pathologise. I'm really not into medical model and I'm really grumpy about the amount of diagnosis of bipolar that gets dished out like smarties* [confectionary]. *It's pathologising what I see to be absolutely ok their experience is a human condition... I see it all the time, bipolar, people going 'I'm bipolar'. People wanting the diagnosis! People come out and say 'I was really happy before and now I'm not so happy' and they want a tablet for it, we get the whole range in this job"* (p. 10).

Neville (2005) argued that as psychiatry took the sharp turn back into the discourse of medicine during the 1990s, psychiatrists became divorced from notions of mental distress within a social or psychotherapeutic model. Horwitz (2002)

suggests that psychiatry utilised biomedical discourse 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, 2012a). 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* unecessarily (Davis, 2013). The social and economic implications of mental illness began to be documented (Mason, 1996; MoH, 2002a; Wing, et al., 1998). The NZ Mental Health Standard Measures of Assessment and Recovery (MH-SMART) outcome initiative is a national programme established to facilitate an audit focused culture in the mental health sector in the late 1990s (MoH, 2012a; Wing et al, 1998).

The Health of the Nation Outcome Scales (HoNOS) was created by Wing and colleagues and arose out of the UK Health of the Nation strategy (Department of Health, 1992) and implemented in NZ as a tool that could be routinely used to measure outcomes for adults with mental illness (MoH, 2012a; Stein, 1999). The HoNOS family of measures (including specific measures for children and older adults developed later) was the first to be introduced into NZ mental health care in 2001 (Cheung & Strachan, 2007). All HoNOS instruments measure mental health as social/behavioural functioning (*see figure 5*) and are required throughout NZ mental health services.

Figure 5: Twelve indicators of social and behavioural functioning measured by HoNOS

Overactive, aggressive, disruptive behaviour	Non-accidental self-injury
Problem-drinking or drug-taking	Cognitive problems
Physical illness or disability problems	Problems with hallucinations and delusions

Problems with depressed mood	Problems with occupation and activities
Other mental and behavioural problems	Problems with relationships
Problems with activities of daily living	Problems with living conditions

Source: Social and behavioural functioning measured by HoNOS: Adapted from: Royal College of Psychiatrists (2003).

HoNOS has been suggested to provide a means to measure the quality and effectiveness of mental health care and are a way in which services can be judged and monitored (Eagar, Trauer & Mellsop, 2005). The HoNOS instrument is used at various points of entry and exit within mental health services by crisis teams, inpatient wards and community mental health teams when admitting or discharging services users. Despite the requirement to use HoNOS, there are a variety of criticisms concerning the instrument.

Critics argue that the instruments lack *psychometric* soundness (Mellsop & Wilson, 2006) whilst others say they lack credibility, as there has not been a comprehensive review of the measurement tools (Kisely, Campbell, Cartright, Cox & Campbell, 2010; Gordon & Ellis, 2013). Criticisms about reliability and validity of HoNOS primarily come from psychiatrists, who are traditionally interested in pursuing credibility as it relates to biomedical discourse. The service user movement and mental health nurses also criticise HoNOS, but through different discourses (Adams, Palmer, O'Brien & Crook, 2000). Mental health nurse academic, Lakeman (2004) asserts that routine standardised outcome measurements can only provide a crude and narrow lens through which to witness mental health recovery. He suggests HoNOS has only a limited capacity to capture the richness of experience of crisis or recovery. Furthermore, in its implementation nurses may be required to collude in practices or account for practice in ways that run counter to the personal recovery paradigm.

Service users also argue that the measurement of effective mental health care

does not equate to a score achieved by clinical assessment (Dury & Munro, 2008; Read & Baker, 1996; Sayce, 1999). Rather, service user outcomes rest on feeling safe, respected, listened to, and helped as essential elements and outcomes of care or intention to treat (Deegan, 2005; Helm, 2003). Māori mental health researchers (Boulton, 2005; Durie, 2001; Kingi, 2005) and clinicians (Dury & Munro, 2008; Tapsell & Mellsop, 2007) further suggest that to enhance outcomes for tangata whaiora [service users] and whānau [family], education of services about the importance of cultural differences and the impact that these have on outcome ratings and the analysis and interpretation of data is essential.

Strategies such as the DSM, MH-SMART and technologies such as HoNOS seek to define and classify symptoms of social behaviour and human experiences, through so-called objective and scientific means. Through such strategies mental health professionals and those identifying the problem of mental disorder become known as experts with their own specialist language (Fisher & 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).

Mental Health Nurse Lucy pointed out that increasingly other government social service agencies, in particular the police, use the MHA (1992) as a means to have responsibility shifted from their agency to the crisis team.

> MHN Lucy stated: *"People seem to have lost the ability to problem solve and it's driven by publicity. You say you're suicidal, so why are you suicidal you know what, it seems like an easy way out, if I say I'm suicidal I'll get some help or they use it as an excuse or rationale not to behave. The police because of their publicity they've had are more vigilant about getting us to see people in the cells. As soon as they mention the 'S' word or know of any psych background... they actually have a checklist and if you say that they automatically get you in to see them. I do think that we see a lot more people than are necessary. I know some people have issues... but we shouldn't be saying 'we don't need to see them'* (p.5).

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.

> MHN Ross stated: *"I think because of the focus on managing risk 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 and blah blah blah you know...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 are so concerned are wanting to cover themselves. The police are worse, somebody comes in, they've taken three panadol, they'd ring the CAT team and they'd 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, what is the mental health problem, they basically fluff around, beat around the bush and say is the person suicidal? '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"* (p. 10-11).

In this sense, the power of crisis assessment, diagnosis and outcome measures constitutes the person as a subject in distress. This renders crisis subjects to

pathology and therefore creates the potential to be acted upon in particular ways regulated by others. Crisis nurses take up the role of expert in a *gung-ho* fashion and default to technologies of normalisation and individualisation (Rose, 1999). However there is a need for some kind of intervention as the reason that people are asking for assessment is to try to prevent suicide. 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 (Bell & Broadbanks, 1998).

Rendering crisis subjects to pathology of mental disorder may well be brought about through technologies of normalisation and individualisation within the training of mental health nurses working in crisis care. 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. Such technologies within a biomedical discourse used in crisis intervention include: clinical codifications, personal examinations, MSE, case study techniques, collection and documentation of personal data, interpretive schemas and the development of therapeutic techniques and interventions.

In our discussion regarding technologies of crisis intervention MHN Violet, summarised the role as:

> *"It's about choosing from limited options, there's only this many resources. You know they* [the service user] *can see the doctor, they can be admitted, or you can treat them at home. They are either sectionable or they are not sectionable. It is actually generally quite clear cut which is perhaps why it is kind of a fix it job crisis, it is in my experience less relational than the key working stuff, where you're going and doing some sort of therapeutic intervention it's really not the greatest priority in crisis work, obviously you aim to reduce distress and then help people manage in the moment, keeping them safe"* (p.4).

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 were suggested to be

physiologically malfunctioning and in principle, no different from any other dysfunction of the body (Cutcliffe et al., 2013). The data above from MHN Violet describes a binary created by the joining together of biomedical and accountability discourses in her statement, *they are either sectionable or not*. Her perception of her practice in crisis work is void of her ethical and professional preference to engage therapeutically and focuses on finding evidence of the criteria of risk and disorder. 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.

Next, I take Foucault's theory of governmentality further with discussion concerning movement of mental health legislation and policy, which shifts responsibility from the state towards an individualisation of social risks.

5.5   Divergence in law and mental health risk policy

Many international authors have published widely on the notion of risk management (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 mental health 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 mental health service users. Furthermore, through ongoing risk analysis undertaken by institutions and the professionals who work within them, populations are understood to be *of risk* or *at risk.*

Significant positive results of risk management practices have been identified, such as prolonged life expectancy, social protection for those who are unknowingly exposed to danger, reduction of symptoms and ultimately prolonged distress due to early intervention indicated through risk assessment (Heffern &

Cutcliffe, 1999; O'Byrne, 2008; Szmukler & Rose, 2013). This normative stance ignores that certain people are thereby practiced on in certain ways. Indeed, mental health service users have in the most part been excluded from contributing to the discourse of accountability or development of risk management practices within mental health care (Byrne, Happell, Welch & Moxham, 2013). Service user accountability discourse on risk is minimal, as are perspectives on positive risk taking. Service user perspectives about risk are often disregarded by the predominant medical and bureaucratic discourses of mental disorder and risk (Bates & Silberman, 2008; Szmukler & Rose, 2013). Furthermore, without inclusion of service user perspectives concerning accountability for risk assessment and management, professional and social implications of risk have cannot be fully addressed. This is particularly relevant given the impact of risk management policy directing an individualisation of risk.

Scholarship on governmentality (Dean, 1999; Foucault, 1991b; Holmes, 2002; Rose, 1992; Sullivan, 2012) has described a range of factors that operate on subjectivity and conduct within the lives of citizens. Giddens (1991) and McNay (1994) argued that agency and self-awareness are greatly influenced by ever-present regimes of practice and are variously distributed across a variety of institutions and social spaces. Agency through self-awareness is the ability to actively intervene or influence particular understanding or experiences pertaining to the practice of self-government (McNay, 1994). The most striking development within the understanding of how citizens conduct themselves in relation to agency is the transformation of personal conduct under heightened levels of societal reflexivity. From this development of societal reflexivity or reflexive modernity, the individualisation of risk has occurred.

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. As a consequence, subjects become enlisted in the ethical government of their own actions through the individualisation of risk (Honneth, 2004). Next, I discuss the way in which subjects of mental health crisis are enlisted in ethical government through the individualisation of risk.

The power of risk policy and further development of individualisation of risk develops through relationships that subjects have with law and policy. This involved the discursive construction of risk management through accountability discourse and policy, where risk is generalised, dispersed and insinuated into the practices of everyday life of the people involved in crisis intervention (Fisher, 2012). The individualised risk appraisal requires the subjects involved to constantly re-calculate problems to which they are unendingly required to attend to. As Andy pointed out, an unintended effect of risk management approaches in crisis intervention has perhaps meant less care and more fear.

> MHN Andy stated: *"Services say they want to provide choices but in reality patients get told all the time 'if you don't take your meds we will put you back in hospital' so being at home isn't about recovery it's about conforming"* (p.6).

In the above extract from Andy, he is recalling the statement *if you don't take your meds we will put you back in hospital* and he himself states that as part of his practice as a nurse working within a crisis service. 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 & Carlyle, 2003).

In contrast to the madness discourse (Busfield, 1996; Foucault, 1988), challenges to traditional psychiatry and its associated coercion and power, have gained momentum. The power of psychiatry was argued by Szasz (2007) to have originated from a quasilegal rather than medical context, so to speak about psychiatry without talk about power, control and the law, would be incomplete. Braken and Thomas built on this notion and state: "substantial power was invested in the profession through mental health legislation that granted psychiatrists the right and responsibility to detain patients and to force them to take powerful drugs" (2001, p.726). The substantial power that psychiatry and with them, their agents and

associates such as crisis nurses wield, has not been particularly debated, although an emerging body of evidence is developing in this area (see Cutcliffe & Happell, 2009; Perron et al., 2010).

It is outside the scope of this chapter to discuss every issue of concern in regard to why people might access mental health crisis services. There are however serious health and social issues which mental health nurses working in crisis services deal with daily, including that of assessment and management of a service user's risk toward self and others (Szmukler & Rose, 2013). Significant policy development has resulted in national strategies and guidelines, which greatly influence the day-to-day practice of crisis mental health nurses. Every year in NZ approximately five hundred people die by suicide and five times as many people will be hospitalised after making an attempt on their life (Associate Minister of Health, 2013). There is an abundance of policy and national strategies which describes factors relating to suicide prevention and workforce development for clinical staff managing the risk of people who are suicidal (MoH, 1998b; 2006b; 2013a). Suicide strategies result in clinical guidelines, which pertain to the assessment and management of risk by health professionals including mental health nurses.

A key recommendation of suicide prevention strategies is that practitioners adhere to guidelines that aim to provide a standardised set of directions to guide them. Mental Health practitioners are to demonstrate evidence-based interventions resulting in the reduction of attempted suicide, deliberate self-harm and suicidal ideation (MoH, 2013a). 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 working in crisis services. 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" (Cutcliffe and Stevenson, 2008, p. 345). Furthermore research which ascertains effective crisis interventions and longer term care or interventions which assist people who experience ongoing risk to themselves, needs to be addressed through such suicide prevention policies (Cutcliffe & Barker, 2002; Cutcliffe et al., 2006; Pirkola, Sohlman & Wahlbeck, 2005).

Clear links exist between nursing surveillance and Foucault's (1977a) 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, p. 170). Foucault's *examination* in the guise of risk management by crisis services has developed through a discourse of accountability. The discourse of accountability includes the strategy of the MHA (1992) and coexists with a biomedical discourse that supports the view of diagnostic labelling to create disciplinary mechanisms widely used by mental health services and nurses as actors within them.

The next and final section of this chapter begins with a summary of Foucault's framework of ethical practice introduced in chapter two. The purpose is to link Foucault's concepts of the *examination* and *surveillance*, which are key to reconsidering the *problem of risk* and will assist with developing in the next two data chapters, discussion as to how ethical practice might frame social and organisational change in crisis services.

5.6   Ethical practice to frame social and organisational change in crisis services

Foucault (1994) suggested that ethical practice can be described in terms of an *ethical fourfold*, wherein behaviour can be problematised, or made the object of critical attention and ethical work (Federman & Holmes, 2005). According to Foucault's idea of ethical practice this includes: *ethical substance*, the *mode of subjectification,* the *elaboration of ethical work* and the *ethical telos* a type of end state or *mode of being* characteristic of the ethical subject (Foucault, 1988b, p.27). Each of these components of ethical practice are elaborated on in the next three chapters. Collectively these four dimensions produce *ethical practice* as a feature of the everyday lives of those involved in a mental health crisis. The people involved in a mental health crisis are the subjects in dimensions of ethical work.

Ethical practice is not something that subjects *do* to another, ethical practice is according to Foucault:

> [n]ot simply self-awareness but self-formation as an ethical subject, a process in which the individual delimits that part of himself that will form the object of his moral practice, defines this position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral

goal (1988b, p.28).

Ethical practice is a multi-dimensional undertaking in everyday practice that is performed by an ethical actor on an ethical substance (Winch, 2005). Ethical substance is the way in which people in a mental health crisis have come to constitute a part of themselves as the prime material for moral conduct (Hook, 2007). A consequence of this process is how people then go about working on some part of themselves, refashioning, redirecting or re-orientating as subjects beyond being distressed. In other words, the work of someone recovering from crisis becomes the goal of re-positioning themselves into the group termed *normal* or *no longer mentally disordered.*

Re-positioning a person in crisis is also demonstrated through ethical practice. People experiencing a mental health crisis are encouraged to disclose their innermost thoughts and feelings to explain their external or *observed* behaviour noted by the assessing crisis clinician or family member (Rudge & Holmes, 2010). A goal for self-disclosure is to provide further opportunity for an expert to undertake the clinical gaze. Constant surveillance as a practice within all parts of people's lives may also contribute to the paradox of recovery for people with mental distress (Rudge & Holmes, 2010). Foucault argued that objectifying the patient or the *clinical gaze* developed from the Age of Enlightenment and the notion that trained experts were seen to be in a position of *knowing better*. Therefore, professionals were *acting correctly* in their role of monitoring and intervention of people with mental disorder. A direct consequence of mental health policy is the dismantling of institutional mental health care to a community or *in situ* oriented regime of interventions and practices to promote a self-governing individual (Perron et al., 2010).

A self-governing individual is subject to *pastoral power* (Holmes, 2002). Pastoral power is where the most private and intimate practices in the service users life, including their home and family, become open to surveillance. In regard to mental health policy and law, the person in distress becomes a subject of pastoral power, where their lifestyle and choices come under scrutiny. Even though policy and practices seek to empower people with mental illness, an argument with a

Foucauldian lens would consider it is a catch 22; recovery both liberates and subjugates simultaneously.

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, Jacob & Holmes, 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, p. 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 within crisis mental health care.

Foucault (1977) argued that although the existence of social and institutional power exists, it couldn't be explained in these terms. Power is seen as all pervading and permeates within every interaction between people and their relationships. The term *panopticism* refers to what Foucault argued as the constant surveillance through which people monitor themselves and in which judgments are made in line with standards set by experts. This type of power operating in today's society could be viewed as practice within mental health crisis services. Perron et al, (2005) argue that nurses contribute 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, 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, all of which are sanctioned by the public and seen by them as a gain in health behaviour and self-management.

The promotion of compliance behaviour through monitoring and health education was termed *bio-power* by Foucault (Gestaldo, 1997). Through such bio-power, sanctioned in documents such as *Guidelines for Duly Authorised Officers* (MoH, 2012) and *The Risk Toolkit* (MHWDF, 2006) it could be argued that people in mental health crisis may be subtly coerced into self-management processes as to prevent further mental disorder. Furthermore, in practice policy documents such as

Let's get real (MoH, 2008) promotion of health education strategies 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.

5.7   Summary

Positioning of users of services has come about through a convergence of biomedical discourses, the 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 chapter I have argued that biomedical discourse has developed and converged with accountability discourse through strategies such as the MHA (1992). Discursive formations of mental disorder and risk management now practiced in the community have continued to constitute subjects of various techniques and practices.

Whilst being subjected to disciplinary measures, individuals are also required to participate in the workings of the disciplinary apparatus of mental health services. The subjects themselves need 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 in order to alert services so that any potential harms 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.

The implementation of strategies such as the Mental Health Act (1992), risk management policy and community mental health policy shaped a newly created field of crisis intervention within NZ health services. The discursive construction of mental disorder, underpinned by a biomedical discourse, is in a context of human practices based on interpretation of empirical and normative understanding. Chapter five provided 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.

The next chapter titled *all fear and no care* provides critical discussion on the dichotomy between dependency-creating crisis services and the notion of self-governing citizens. A discourse of personal recovery is explored through analysis of data from participants to discuss the formation of a discursive construction of uncertainty. I argue in the next chapter that the experience of uncertainty is silenced in the process of accessing crisis services. A discursive construction of uncertainty is related to a discourse of personal recovery being marginalised and overridden by a predominant discourse of social development so that expertise is privileged.

Chapter six: All fear and no care

6.0   Introduction

In the previous two chapters I discussed analysis of what Foucault termed a domain of truth to demonstrate the mechanisms through which people in crisis become constituted as subjects. As demonstrated in the previous chapter, positioning of users of services has come about through a convergence of biomedical discourses, the 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.

Biomedical discourse has developed and converged with accountability discourse through strategies such as the MHA (1992). Discursive formations of mental disorder and risk management now practiced in the community have continued to constitute subjects of various techniques and practices. While being subjected to disciplinary measures, individuals are also required to participate in or conform to disciplinary apparatus of mental health services.   When subjects participate in and conform to the needs of the service, they are 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 in order to alert services so that any potential harms 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.

The implementation of strategies such as the Mental Health Act (1992), risk management policy and community mental health policy shaped a newly created field of crisis intervention within NZ health services. The discursive construction of mental disorder, underpinned by a biomedical discourse, is in a context of human practices based on interpretation of empirical and normative understanding. Chapter five provided 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.

This chapter furthers discussion on mental health law and policy and develops an argument concerning the dichotomy between *dependency-creating* and *self-governing citizens.* This relates to how the strategies are used differently with people to result in different outcomes in relation to service provision. This may mean that people are required to act and position themselves in particular ways in relation to services or be held by services for long periods of time despite little effective intervention. Data from the participant groups are presented. Foucault's theories are used as a framework by which to analyse the data that people who use crisis mental health services make about their experience. The analysis can enable us to build a picture of the forms of power that takes place, how that power is used to subjectify people, and the interactions that take place. The analysis provides new sets of criteria by which to understand and evaluate crisis mental health care that is grounded in understanding how people who are involved in services negotiate and navigate particular dynamics of power that direct their position as subjects and consequently their conduct. In addition, this kind of analysis can develop the potential to find new ways in which to consider crisis mental health service care and to uncover the problems that services present to the people who use them. Foucault (1991b) asserted that it is only by working with the people involved in specific situations that the problems they face can be solved (McNay, 1994; Strozier, 2002).

6.1   Dealing with the institutions

Discourses evolve in response to internal and external pressures, thus they incessantly produce effects on their discursive subjects and objects (Garrity, 2010). Objectification of services users and families in crisis is achieved through the process and practices of bio power. Within bio power the process of dividing practices and descending individualism take place. Firstly, dividing practices operate through the various disciplinary institutions, which emerged in the 19th century (Rose, 1999). Such institutions included prisons, workhouses, schools and hospitals which according to Busfield (1994) *took hold* of the bodies and minds of their inhabitants and shaped them according to disciplinary procedures and quiet coercions. Disciplinary institutions exist today through the governmentality of dividing

practices. Dividing practices are the ways in which social groups are separated from one another on the basis of judgments made about their actions and attitudes (Rose, 1999). For example, the mad are divided from the sane, sick from healthy, poor from rich, criminal from legal (Busfield, 1996).

Secondly, descending individualism is the way in which modern western societies more closely monitor people and individualise them based on their ethnicity, sex and socioeconomic status. According to Foucault (1994) under the order of feudal societies and monarchical rule, the more powerful one was, the more watched and noticed one became. Descending individualism operates according to an opposite effect through increased collection of data about those subject to surveillance or in need of supervision, for example, prisoners being monitored by guards, pupils by teachers, children by parents, patients by doctors and nurses and so on. Individualisation of service users and families through normative judgments used throughout crisis services and various other government agencies results in people in crisis being *silenced*. The process of being silenced in crisis leads to those involved acting as they are told or being directed to (Bussolini, 2010). In an effort to avoid the stigma and ongoing scrutiny associated with mental illness and potentially the type of interventions and consequences to those interventions, service users go to great lengths to conceal their distress from families and health professionals (Gregory & Thompson, 2013; Rabiee & Smith, 2013).

Origins of mental health problems in the past and in the present are described by service users and families in this study as a process of stressful life circumstances and factors, which precipitated for them, a mental health crisis. Descriptions of people who have experienced mental health problems and their families have been a popular pursuit in the fields of research, film, television documentary and talk shows. This is in contrast to the historical *out of sight out of mind* mentality that existed prior to a growth in the interest of reality oriented media which surfaced stories about being mentally unwell from the people who had experienced such phenomena (Lapsley et al., 2002). Before the process of deinstitutionalisation of psychiatric care in NZ, people deemed mentally ill spent most of their lives within institutions and were frequently separated from their families as part of their treatment.

During the years that followed the closure of large psychiatric hospitals, mental health services perpetuated therapeutic models that highlighted the negative influence of family systems (Gleason, 1999; Goodwin & Happell, 2006). Mental health professionals were conceptualised as advocates assisting to shield service users from the possible dysfunction and damage that family were seen to impart on their lives (Clarke, 2006). With the devolvement of psychiatric care to the community a shift has occurred in the living situations of those labelled with mental illness and as a result service users frequently live with family or see them as a primary social support within their recovery. In spite of this increased family involvement and extensive research which supports collaboration between mental health professionals, families and service users, families rarely report that they receive adequate information, resources and support from mental health providers (Rusner, Carlsson, Brunt & Nystrom, 2013), especially when in a situation of crisis (Lyons et al, 2009; Walsh, 2013). So, exploring with service users and families the types of situations that deemed necessary to deal with a crisis was a key focus in this study. The purpose is not to reconstruct the lives of service users or family members, but rather to explore how participants experienced their family life, of which mental illness became a part.

By the time the Mason Report had been published in 1996, service user and family support organisations within NZ had been established with limited visibility for approximately ten years. As far back at the 1950s, there was scant representation of service user voices such as Arnold Brookers, notable Wellingtonian and solo campaigner for rights of psychiatric patients (MHC, 2007). Later than this, but also sporadic in their unity and profile were patient rights and self-help groups such as the *12-step – Grow programme* (MHC, 2007). In the 1980s development of the Psychiatric Survivors group, Auckland based and led by long time activist Mary O'Hagan joined the Aotearoa Network of Psychiatric Survivors (ANOPS), led by Pauline Hind (MHC, 2007).

Prior to these early organisations establishing a variety of service user led participatory activities such as peer support groups, input into local and national mental health services and the formation of advocacy networks, government agencies paid little attention to service user or family stakeholders in the development of health policy (Wilson, 2000). In 1995 the inclusion of service user consultation and

consideration of family participation in advisory roles became a reality with the Ministry of Health publication of *A Guide to Effective Consumer Participation in Mental Health Services.* This was reinforced following the publication of *Moving Forward: the National Mental Health Plan for More and Better Services* (1997), which included a national policy objective to improve responsiveness of mental health services to consumers and families. This signalled directly to mental health services that users and families were to be involved in the planning, design, and purchase of services nationally. Despite governance level involvement of people who experience services and their families, little of significance seems to have changed. In the next section of this chapter I argue that involvement in the development of services seems far removed from the experiences of service users and families who participated in this study.

6.2   Seeking care

Getting help and fear of being judged was described by the participants as a problem when experiencing distress and dealing with crisis services. Tony and Judy, parents to Troy, found that the more they questioned why their perspective of acceptable help wasn't available in times of crisis, the more services seemed to resist their requests for support and this led to an escalation in distress for all and involvement with the police. Tony, a parent, stated:

> "*We became a 24 hour mental health unit, at home which is pretty much what a lot of families have done…we were trying and I had rung the crisis team and I said 'look, you guys are just not going to get away with this...Yeah, so we had to bring in the police and so they said do you know where he is, and I said, well, he's in* [name of town], *but I don't know where he is exactly. So they put out a missing persons and then you try and bring in the crisis team, well we finally worked out that he was outside of my sisters place and so I rang and I spoke the police again and said, 'I know where Troy is now, can you send someone to pick him up?' And they said they had no right to go to someone's property and take Troy and admit him, that's what I got from the police…I got a constable who was really inexperienced. So I rang the crisis team and they said 'did you ring the police', I said yes, and they are refusing to go and then the guy from the crisis team said 'well, we're a bit reluctant to*

go, are there any knives in the house?' and I said 'hello, it's a domestic house so there are knives in the kitchen, so they just refused and Troy walked from that address" (p. 5-6).

Participants were reluctant to instigate contact with mental health services, even after they had seen crisis nurses before or sought help from some other social support agency. In the extract from Tony above, he is making the point that the more *known* a service user or their family is to crisis services, the more likely the service is to restrict access.

Theo, a service user in his mid 50s had a fairly lengthy relationship with crisis services in different parts of the country. He would go on to have intermittent contact with crisis services but settled in one particular area approximately five years ago. As Theo, a service user, describes:

"*I felt reluctant to ask for help, I think one of the key problems we have is especially as men with mental health problems, is that we've got our pride and it makes it hard to ask for help. I didn't ask for help and at the time I didn't think I needed it, but I ended up in a half way house for waifs and strays and after that I was on the streets*" (p. 3).

Henderson, Evans-Lako and Thornicroft (2013) suggest that more than seventy percent of people with mental illness receive no intervention from mental health services due to a perception that they or their family will experience prejudice and discrimination from the community.

At the beginning of contact with crisis services the participants had differing experiences of how power was exercised over them. Some of the service users and family members noticed that there were conflicting messages about who was *in charge* of their crisis situation. Parents Judy and Tony had multiple occasions to call the crisis team and described ongoing frustration with feeling heard by services, Tony stated:

"*You get told that's your problem but if you are a family member and ringing for help it's a crisis, we are not ringing for fun, it's usually a matter of life or death...but if you say that the crisis team says ring the police and you ring*

them and they say it's a mental health issue. The police are there for care and protection of the community but they really don't know what to do' (p.9).

On trying to access information or assistance, Lola, a service user, stated:

"My counsellor didn't really know how to handle me, they didn't really refer me on or do anything, there was no follow up… so that was quite distressing and eventually I got myself to my GP, he immediately dropped all his appointments and took, drove me himself to the CAT team…when they [crisis team] saw me they took me down to this other room it was like a big meeting room um because all the other rooms were full and I just freaked out, I just couldn't really handle that - it was the big unknown too, like everything was so new and all my perceptions of mental health services being very coercive and my fear of taking drugs and that made it really hard for me to actually access the service" (p.1).

At the time of crisis most participants felt like they were incapacitated in some way and felt *broken* as Emily, a service user described her experience of escalating stress following her termination of employment, she said:

"I think mental health crisis had been building up for years, since I was about seven, there had been all this shit, just building up in me, the job was the final straw, I just totally crashed and burned" (p. 6).

Emily, like Julianne who is also a service user, did not feel in a position to self-care during the experience of initial crisis and saw herself as being dependant on others. In Julianne's experience she was not necessarily heard until things got out of hand for her and she was taken to hospital under the Mental Health Act (1992). Service user Julianne says:

"I ended up going to hospital, I never quite found out what happened, they said I broke a cup or something, I don't have any memory of it so I don't know if I broke anything, but they [crisis respite worker] were like, get her out of here – take her to the ward…I'm not sure what I did but I was clearly kind of out of control, so they took me to hospital" (p. 5).

On one particular occasion when Rosemary, a parent to Darren, had engaged several times with the crisis team about seeking assessment and care for him things from her perspective became very distressing. During the interview Rosemary showed me extensive notes, letters and a diary which she had kept concerning this next part of text. Parent Rosemary stated:

> "*I got a call from the ward, Darren had been admitted the night before and he was extremely agitated and the nurse told me that Darren was going to leave and he could come back at anytime. I said 'don't let him out, he's unsafe'... they let him out and I had to go and pick him up, he was very unwell, he told me I had abused him all his life and that he'd got taller still since being in the ward and that he'd grown wings that were coming out of his body, as I sat with him in the car, I just didn't want to come away, but they* [the ward] *said 'oh the psychiatrist said he has to go home"* (p. 5).

Rosemary took her son home and that night described feeling very alone in the house with him as he was up most of the night making phone calls. The next morning Rosemary rang the psychiatrist who told her to contact the crisis team and was told once again that her son could not be admitted. Another night passed with Rosemary stating that things continued much the same and described herself as not sleeping and becoming very fearful. The next morning she said, as if facing a firing squad:

> "*I couldn't go to work, I thought Darren was going to go out and get lost in the bush again so the psychiatrist said that he could come in for a few days if it was voluntary, but he said he wouldn't...anyway, we* [the crisis nurse and Rosemary] *got him up there and **then faced the doctor** and the psychiatrist said to Darren 'how are you?' and he said 'I'm fine thank you' and I said 'excuse me I am his mother and he is totally unwell, I am afraid for his safety...he's on medication, he's driving his car, he could kill someone else or I am afraid he'll die himself' and they* [crisis doctor and others present] *said 'no, he can't come in, he seems fine to us'. I told them I had been deceived, that the ward had said they were letting him out but if he was unwell he could come back in and they went really mad at me and told me that it was my fault he was ill, they said 'you are such an extreme person, that's why your son is ill, you shouldn't be near him"* (p.6).

Other participants were seeking feedback from others as a means to ground what was happening to them in their sense of losing control. Marie, a service user encountered her first assessment with the crisis team via a referral from her GP. As Marie suggested, she looked to the crisis team for symbols of explanation about her fearful thinking:

> *"I don't know how I felt then, it was as if part of my brain was actually thinking very bad things and the rest of me was fighting it. It was overtaking everything; even when I was asleep, it was thinking bad things, like kill yourself, you could do it like this – you have the things, do this, do that. That's the trouble with people's thinking, the way they think when they are suicidal. You ask yourself is that you being suicidal? It's not you, it's somebody else – that was what I was fighting with but at the time I just wasn't strong enough, I needed someone to help to tell me where I was"* (p.3).

Bebbington, Kuiper and Fowler, (2013) in their discussion concerning shared decision making in crisis, argue that the main reason that service users remain reluctant to take up opportunities to participate in their own recovery is due to their perception that services hold that users and families are generally unskilled or uneducated and so, are unable to make independent decisions and take action.

On an individual level of participation authors suggest that mental health providers are sometimes focused on convincing patients that services are right and sweep aside patient priorities and preferences for what aspects of recovery in which to participate (Pilgrim, 2008). Mental Health Nurse Andy spoke of who heads decision making in his view. He stated:

> *"I saw a young fella, 13 year old, he had minor cuts and a bit of a history, saying he was suicidal, I had seen him a couple of times before. There was a big hoo-ha with CYFS* [social welfare protection and care agency for children and families], *the police, whānau – all sorts involved. But I knew, he needed a word to pull his head in...there is a lot of written but also unwritten information that we retain in this job"* (p.11).

Florin, Ehrenberg and Ehnfors (2005), found in their comparative study of nurse and patient perceptions in decision making, that care providers attribute significantly more health needs to patients than patients do to themselves. Little research on the priorities of service users, from their perspective during crisis has been written about in literature. However exploring priorities in recovery with service users receiving long-terms support from mental health services is more common.

Latvala, Saranto and Pekkala (2004) in a study concerning the development and testing of instruments to improve cooperation and participation between mental health nurses and services users found that providers of care tend to focus more on reducing symptoms, enhancing patient satisfaction and preventing future relapses. However, patients were concerned with developing more independent living, having positive moods and shedding stigma of mental illness as key treatment initiatives. On how her input to decision making as a service user was regarded by the crisis worker, Julianne stated:

> *"I'd seen like the Bill of Rights, the crisis nurses gave me the Health and Disability rights, a pamphlet or something, but it didn't feel like those rights were really relevant because a lot of them go out the window the moment you are under the Mental Health Act anyway even after I told them I would go to hospital they still used the Act on me and it marks you out for life"* (p.2).

Foucault's term *dispositive* is "a thoroughly heterogeneous ensemble consisting of discourses, institutions, propositions…in short, the said as much as the unsaid" (1977b, p.226). The powerful biomedical and accountability discourses within crisis services that involve strategies such as symptom reduction, risk management and limiting access occupy a privileged position in a way that undermines personal recovery discourse.

An action research study by Lyons et al., (2009) on service user and family participation in crisis and respite services, found that at an individual level, service users had to wait until a crisis had escalated to a level in keeping with access criteria, or in line with the MHA assessment threshold, before their situation could be dealt with. Sergeant A had been in his role with the police since the introduction of the MHA (1992). Whilst he commented that the relationship with crisis services had

improved over the years, self-preservation within his organisation frequently accounted for increased calls to the crisis team. Sergeant A said:

> *"Nowadays we call crisis far more than we used to, we appreciate it's a problem for them too but we have just gone through three years of suicide prevention training and it's about not being complacent, you don't just chuck them in the cells, gotta make sure you tick all the boxes, label them at risk and a part of it is us being more fearful than perhaps we used to be"* (p.2).

Time delays and waiting for services to make contact despite frequent requests and having to wait to see clinicians in venues such as emergency departments or community mental health settings added to the stress of crisis for service users and families and put them off participating then and in the future (Lakeman, 2008). Examples from participant data illustrate that when service users do participate and take initiative in crisis they are often met with service driven barriers.

Families too suggest there are significant barriers to participation in crisis at home and in clinical service settings (Goldsack et al., 2005). These include unnecessary waiting times for appointments or return phone calls, an inability to speak about of have information about what was happening to their family member, poor communication with staff and a lack of choice about what level of involvement they could be included in (Barnett & Barnes, 2010; Lakeman, 2008). Participants involved in this project suggest obstacles to participation are likely to be an ongoing challenge for individuals and families and contribute to increased service access being driven by other health and social service agencies such as the police.

Building and strengthening service user and family perspectives and involvement is a key objective of NZ mental health recovery policy. However like the early objections raised by Foucault (1988) and Szasz (1961; 1997), which challenged the medicalisation of mental illness and the resulting controlling treatment, it seems that crisis services are more firmly grounded in biomedical and accountability discourse and a strengthening discourse of social development termed by participants as the ways and means they are excluded from services and subject to being managed as a *case* for experts to decide about. The next section of this chapter furthers an argument that the divergence in mental health law and policy is creating a dichotomy between dependency creating services and self- governing citizens.

6.3   Being objectified in crisis

During her first contact with the crisis team Julianne, a service user, was initially labelled with a diagnosis of borderline personality disorder but in a later encounter with crisis services she was diagnosed with a schizoid personality and then depression. For Julianne, the change of label was a relief as she noticed that the crisis team treated her experience as being more legitimate than her friend who continued to be labelled with borderline personality disorder. Julianne stated:

> "*Initially they named it borderline personality disorder, that particular label is unfortunate really, but next time I saw some doctor who yelled at me on my last day in the ward – you are schizoid-something, I think it was schizoid-personality disorder. It's some sort of lesser form of schizophrenia; it's not quite as interesting* [laugh!]…*then a doctor wrote down for me on a piece of paper – he wrote you have got depression and oh, finally someone said I was depressing – Whoa! I made it to Axis One! Now I can get some help with all this*" (p.14).

Crowe (2008) argues that the term personality disorder is common in the mental health settings and is often used without critical consideration. Personality disorder has pejorative connotations, which arise out of the way in which a person's emotions are constructed as behavioural rather than psychiatric. Furthermore, the construction of some personalities as disordered and, therefore, illegitimate becomes natural.

Other participants noticed that the crisis team encouraged or discouraged self-care dependent upon the reframing of their experience within a diagnostic category. When service users were told by the nurse or doctor that they had a diagnosis and met the criteria to access services it came as a relief.   However for others, the label they were given brought about new obligations and a message that they were being spared from something far worse, but only if they remained managed by experts. This causes service users to follow orders from family and crisis workers including acting on instructions about taking medication, turning up for follow-up appointments and an obligation to impose as little as possible on the services. A family member, Ruby discussed her experience when her sister had accessed services of the crisis team via an assessment in the emergency department.

Ruby experienced a change in family dynamics with her parents and in her role as a sister. She found herself questioning the practices of the crisis nurses and motivations of her own family members, as help was mobilised for her sister. Family participant Ruby said:

"We were in A & E and the doctor asked the crisis team to come in. When they finally got there, it was 4am and it was the same nurse who had been round to our flat earlier. I heard him talking around the corner to another nurse saying that if [name of sister] *was drunk again then he had to wait, but she wasn't drunk, she had been drinking but she was totally fine to talk to the psych nurse. I didn't like him, it was like he was really bothered by having to be there, really put out, like we were causing him trouble or something…luckily none of the other nurses I have met from the crisis team have been like that, he was a real creep, totally up himself…anyway he did end up speaking to her and I can remember just thinking I should take her home. He spoke to me about what the options were,* [name of sister] *didn't want to go into hospital but she couldn't stop crying and then dad arrived and he spoke to the nurse and he filled out some form and she went over to the psych ward and was told she had to stay there. I just felt sick but she couldn't come home, she was totally unwell and even though the nurse said she could be followed up at home the next day, my dad had made up his mind that it wasn't going to happen"* (p. 4).

One of the key issues presented in the research report *Support for families, whānau and significant others affected by a suicide attempt* (Beautrais, 2004) is that there is a lack of awareness of services available to support people affected by a suicide attempt and that "there are no support services available for siblings" (p.13). Furthermore, in the Goldsack et al., (2005) report on home based treatment in crisis, the authors noted ongoing dissatisfaction from families about venues for assessment and treatment and argued that rather than services screening out options for home-based care, institutional resources should be reallocated to community venues preferred by service users.

Another way in which service users were more likely to become compliant with services and allow themselves to be case managed was for fear of perpetuating an ongoing experience of uncertainty. As Theo, a service user, stated:

> *"In my own experience I had a GP that failed to recognise the fact that I was in crisis when I went to visit him on another matter...he failed you know he knew I was bipolar, he didn't see the irrational behaviour I was displaying. Now I have two things I adhere to, one of them is that I have got good self-discipline, I learnt that in the [name of services], I can self monitor if need be until it dissipates to a point of when I start to get manic. The main thing is that if I look after myself, others will see that I am looking after myself and then others will help when need be'* (p. 3).

For Theo this meant a decision to live in supported accommodation as a means to help keep himself in *check* with the mental health system and prevent the need, or at least reduce the impact of further times of crisis and being unwell. Crowe (2005) argues for a focus on how the epistemological foundations of psychiatric diagnosis have promoted individualised pathology and made available a whole set of diagnosis and interventions for people in crisis, which can lead to unwanted changes their lives. Furthermore, Thomas and Braken (2004) show how psychiatric labels create particular pathologies assumed to be personified in individual identities, thus creating individuals as subjects of professional intervention, and play a role in the maintenance of professional power. The idea of self-surveillance and monitoring one's own progress and safety in crisis follows next.

6.4 'You had better keep an eye out'

Objectification of service users in crisis is driven by strategies of diagnostic regimes such as the DSM V (APA, 2013) within a biomedical discourse, which marks out a deficit in the person experiencing distress. This entails service users being either screened out through triage processes (not sick enough) or being labelled with a diagnosis (sick enough to require help and dangerous). Service users of crisis intervention have to be diagnosed with a DSM V: axis one diagnosis, to meet the criteria for mental health services (APA, 2013; MoH, 2008c). Whilst crisis services provide for self and family referral, any potential intervention, which may assist the person in recovery, is only on offer if a label can be found of mental disorder and

risk to self or others. Mental disorder is identified through technologies such as the mental state exam, that contribute to the strategy of the DSM and DAO consultations in the strategy of the MHA.

Biomedical discourse comes from belief in the power and truth of science and involves acceptance within society that mental disorder can lead to a deviance requiring control. This creates a perception from health professionals and the public that people experiencing distress are often thought not to have an inability to make decisions (Chong, Aslani & Chen, 2013; Owen et al., 2013). From a Foucauldian perspective, consideration of how dominant discourses have come to occupy a privileged position at the expense of subjugated discourses shifts the power from the professionals to the users, especially in making service user's voices heard and their choices upheld.

The first strategy to problematise is how the experience of distress and the key assumptions about the problems being faced by service users are framed. Service users in this study took personal meaning in everyday life situations, problems of living as described by Szasz, as the problem of distress and wanted to retain power to access services when need be. However, the nurses and for the most part, families framed the distress in terms of biological symptoms, causality orientation, potential damage through lack of volition and a problem orientated approach. When people come into contact with crisis services a dialogue with the nurse determines how mental health problems become conceived. If one perspective is about how life is being lived and the other is about deficit and risk then how the problem will be tackled and the ability to participate in a crisis plan is likely to be dominated by a biomedical discourse. Various authors argue the need for appreciation that the person experiencing distress is trying to make sense of their situation (Barker, 2009; Jackson-Cherry & Erford, 2010; Watkins, 2007). The issue to be confronted is how to bring together the difference between the service user and family perspectives of mental health crisis and that of the professionals and policy makers. This would involve negotiation of a different crisis discourse, one which values service user knowledge and experience in determining what change might occur.

The second issue is to re-examine how the idea of risk within crisis intervention has become so widely accepted. Foucault (1988) argued that without the emergence of scientific knowledge and rational explanations of the world, there would have been no mental disorder or illness, as we understand it today. His perspectives of how knowledge/power heightens our attention toward specialised knowledge and the governing of our actions through powerful institutional structures such as mental health care. In crisis services the specialised knowledge can be seen in the roles and actions *designated* to nurses (DAOs) and doctors (RCs) through the MHA (1992), mental health policy and guidelines. With an expert knowledge being perceived as on offer, families, health agencies, the police and others seek the crisis nurses out as authorities and experts on the service users experience of distress. In turn, those with so-called expert knowledge make decisions based on strategies within social development discourse such as *best evidence* from mental health policy and clinical guidelines. However, service user knowledge does not have great standing in the hierarchy of evidence knowledge. What can and does result is a potential domination of service user by means of force or coercion or in other cases, no action toward change. This highlights further binary in the dichotomy of dependency creating services and self-governing citizens.

6.5   Playing the game? Descending individualism

Service users and families in this study described an ongoing conflict in the experience of engaging with or avoiding the watchful eye of others during the crisis and well beyond. For Lisa, a service user, this was a mixture of different types of monitoring which ranged from her ex-partner, to the police, to mental health and social services. Lisa stated:

> "*We were having problems my partner and I, but it was him that I would turn to when things started to get out of hand...I didn't know what else to do, I wanted to commit suicide, so I would ring him and he would ring the police. After that a nurse came to see me and took me to a respite house and that sounded really good cause I just wasn't in a position to look after myself it was good to get away from my own space, and you know, my own house and also my responsibilities cause I just wasn't in a position to look after the children*" (p. 1).

Later on when Lisa had been in crisis respite as an alternative to inpatient admission she was sent back home to her partner. Her partner was designated by the crisis team as a *responsible person* to monitor Lisa during her recovery. However, neither Lisa nor her partner welcomed this obligation and she suggested it resulted in ongoing conflict between them. Lisa described how she learnt that multiple people or agencies were dispersed to provide surveillance over her, she said:

> "*I was just trying to present the way I thought they wanted me to be like, I just wanted to go home. But things didn't really get any better and during a few months there were quite a lot of crisis interventions with the police. Daily I was feeling like I was at the end of my rope before I even got up. I was quite lonely and at nights it was worse, I would have started drinking or doing other drugs and by night I would be feeling really frustrated and I would get angry and start to hurt myself, I would reach out to my partner aggressively, then he would ring the police and they would ring CATT and they would take me away if they needed to or stay long enough to make sure I was OK*" (p. 3).

Learning the rules of how services work or not became a pattern of danger for Lisa and for another service user, Rehu, the rules led her to a belief that she was to blame for her own inability to accept services when they were being offered.

Rehu suggested that her contact with the crisis team was initially a shameful experience for her at the time; later she was to reframe this as a time of lost opportunity and regret. Following an overdose and her first contact with crisis services her GP prescribed antidepressants. In our conversation Rehu, a service user, stated:

> "*They* [crisis services] *wanted me to take medication properly but I would throw them away because I can't stand how I feel on them. What use is having them I think to myself, I go like that then I take a whole lot of them and you know, just about do myself in, so to me it's just bizarre. I was scared to have the medication. My brother said you know you are on the pills, they just say it's a illness eh, and I think this year I am just trying to accept it cause I was in denial about it, you know – like everything was cool, but it wasn't...I don't really think they* [crisis team] *are there. I mean you can call*

the number when you are like that and they told me when they first came that if I felt really sad and out of it, you know, and if it was after hours to ring them, but they don't have no answers...and then they hang up and it's not until you are in A&E again... It felt like there was nothing that they could do until we actually do something or something happens, I don't feel like there was support, I don't know..." (p. 6).

Having felt embarrassed about her distress, Rehu initially avoided any intervention following an overdose but began to think that she may have not only missed an opportunity to get some help but that the team she dealt with may have been using certain tactics to avoid her engagement with crisis and potential ongoing recovery interventions.

Interventions that provide people in distress the opportunity to learn about and reflect on what does and does not help in crisis was minimal from the perspectives of participants in this project. Most options seen by crisis professionals were dominated by institutional regimes of compulsory assessment and medication management or use of broader outcome strategies, such as HoNOS, to screen out the need for further interaction with services.

Service user participants suggest the right level of help was not available to them and that they were told to behave and what to do, which dictates power. This raises a further question about an intention of services to facilitate independence or is it more about minimising use of resources and protecting the backs of health professionals, which keep people experiencing distress under unnecessary control and serve to strengthen a discourse of accountability. Whilst accountability supports this use of power with an expectation that professsionals make decisions regarding safety and risk, resources are not avaliable in the way that people expect them to be.

Service users and families may identify the need for help when they perceive something is wrong, but it does not necessarily mean anything is available for them. The gap in expectation and availability of services need to be managed. Those working within crisis services have to scrutinise power issues within their relationship with service users and families (Gregory & Thompson, 2013; Loughran, 2011; Sawyer, 2008). They can do this by examining how interventions aimed to

assist people toward independence and self-care may be used to counter dependency-creating services (Mackay, 2011).

Elaine, a family member participant and partner to Chas, found the gap between expectation and availability of help was a time of danger. Elaine was the first person to support Chas during a prolonged period of distress, which culminated in an overdose of alcohol and prescription drugs. Elaine described going with Chas to ED where he was monitored then briefly seen by the crisis team, she stated:

> *"The doctors there did all these tests then the crisis team had him in there for about 45 minutes and then I went into the room and they said they were going to let Chas go home and that they would be in touch the next day and I was quite shocked, cause it looked like we'd just had marital problems and it was more than that"* (p.2).

Elaine ended up taking Chas home in her car and putting him to bed on the couch, but the next day things got significantly worse for the two of them. She stated:

> *"I got up and Chas was sitting on the couch with the phone in his lap and his eyes were like dark demonised, it was quite scary, I don't know how else to describe it, um, he wasn't himself and I was petrified...to cut a long story short he ended up trying to kill me and he nearly did, he put his hands around my throat and tried to strangle me, and then he let go and went around to his mums place, he wasn't himself, he was completely out of it "* (p.3).

Elaine rang the police and Chas's mum concerned about him however, the help she was looking for eventuated in Chas being charged and detained in prison. Elaine said:

> *"They arrested him and wanted to take photos of my injuries, they put him in prison, he went to court and basically it wasn't what we expected, I expected the police to call the crisis team"* (p.3).

Although this was a stressful and confusing time for Elaine, her main concern was to access the right help for Chas. She described the initial confusion, which became an ongoing problem of accessing crisis and continuing care within mental health services. She said:

"The police said the crisis team would help, that they would contact them but they ended up wanting to charge him with attempted murder, I was absolutely shocked...I ended up having to change my statement to get him off the charge...I had issues of my own and otherwise, Chas was going to end up looking at prison term. When he was seen in court the judge said if he admitted that he had done wrong, he'd make everything go away and then he was under forensic mental health [Forensic mental health services see people who are thought to be mentally unwell at the same time as facing criminal charges or sentencing through the court system]. *But when he was released from prison there was no forensic mental health and normal mental health, well, he couldn't get into them because he had been forensic, then we started this very long battle of trying to get help for Chas"* (p. 4).

Alongside this, Elaine said she had recognised that trying to take control over the situation that Chas was experiencing only left her feeling like she had to *parent him* and what she really wanted was mutual support and reciprocal care within a partnership. Instead she was left with the perception that she had a new sense of responsibility imposed on her.

Provision of community crisis services brings with it several sets of challenges for families. The growth of numbers of people thought to be experiencing long term mental illness, and with that, increased need to access crisis recovery services (MHC, 2012a) potentially equates to more reliance on families to *care for* their group members who are subject to services. Despite this, nurses and doctors within crisis services continued to be legitimised and strengthened through the operation of biomedical and accountability discourse. Strategies and technologies within these discourses can be used as a means to govern and control and justify labelling service users as a risk to themselves or others. However, despite potential control being exercised upon service users and families, there is opportunity to explore points of resistance, which occur in accessing services.

In this study, I argue that crisis nurses exercise social control over service users and family members. Their mandate for social control is underpinned by their every-day role as social agents sanctioned in mental health law and implied authority within public health policy. Crisis services are positioned as experts and gatekeepers

to a scarcity of resources within a social development discourse and so are encouraged by service managers to monitor and minimise allocation and control access to mental health resources.

The MHA (1992) whist not directly concerned with crisis service delivery contains a number of provisions, which relate to crisis responsiveness. The MHA sets out a statutory definition of a person who may be subject to compulsory assessment and or treatment. The definition establishes a threshold related to the symptoms service users may display as well as a degree of seriousness of the impact of these symptoms. The MHA does not intend to preclude people who do not reach the threshold from obtaining crisis services but simply establishes the criteria for application of a compulsory process (Chaplow, 2011). Yet, in the participants' recollection of accessing care for their family members there did not always appear to be any such threshold or criteria. Families found that they were subject to changes in the rules of crisis services and increasing imposition of taking responsibility for the potential risk associated with their family member.

In the discussion with Sergeant A, he also was concerned with impact on the families and said that both the crisis team and the police had an ethical responsibility to respond to service users and families in a different way. However, whilst he conveyed the need to respect individual needs his statement reinforces discourses of accountability, Sergeant A said:

> "*We need to be thinking you know about how it would affect somebody if somebody commits suicide in our cells, i.e. everybody that we deal with, some people really piss us off like bad criminals and paedophiles and that sort of thing but you know what we say to our guys 'everybody is somebody's son or daughter or brother or sister or father or mother type thing and you need to put yourself in their shoes'…Obviously we've had a lot of public scrutiny for the last five or 10 years particularly in the last five years and we've had to really work hard to try and get back the confidence the public used to have in us, so part of that is about doing the right thing and being seen to do the right thing*" (p.3).

NZ police systems concerning the prevention of suicide have been overhauled dramatically since the late 1990s (MHF, 2012). Police officer training to address the

needs for increased interpersonal skills and reducing crime victimisation in adults with severe mental illness has been a feature (Reuland & Schwartzfeld, 2009; Teplin, McClelland, Abram, & Weiner, 2005). The excerpt from Sergeant A further strengthens the policy discourse underpinning the discursive construction of expertise and aligns risk management within the accountability discourse. Whilst literature regarding police response to individuals presenting with mental health issues has an increasing focus on justice toward the individual, the police firmly take the stance of preventing injustice to society (Fisher & Grudzinskas, 2010). Furthermore, the perception that the criminalisation process occurring for people with mental illness has become a driving force behind increased health services at the interface of the mental health and criminal justice systems (MHA, 1992). The discourse of accountability evident in the criminal justice system converges with social development discourse.

Delegation of clinical tasks from health professionals to family members, such as monitoring of suicidal thoughts and intentions, medication administration and compliance of other treatment deemed necessary through accountability discourse, was talked of frequently by the family participants. Chris verbalised his relief to have his wife's experience of distress explained by crisis services in the form of a diagnosis and prescribed treatment. Chris, a family member, stated:

> "…*I think gaining the knowledge, is the biggest thing out that was the best support I could have is being able to fathom what's going on and being able to recognise the signs cause it's so often now I think I have diverted a major crisis because I've been able to say 'hey* [name of wife] *you know I think you are having a bad day' and she'll say 'yep, yep' and so you know, I've become the prescriber really cause I know the medication now and we can give her some PRN or something like that and on a couple of occasions rung up the doctor and said I've said 'look she needs more of this' - haven't even seen the doctor...*" (p. 7).

The examples from family participants Elaine and Chris and Sergeant A's stories clarify a significant amount of trust invested in diagnosis and treatment by crisis services. However they signal also a new found authority installed in families, by services, to be responsible for and accountable to others. Furthermore transference of

clinical tasks to family repositions them to an alliance with professionals and further silences service user personal recovery discourse. Belief in professional knowledge and agreement from family to take on a surveillance role brought with it new responsibilities and an unintended isolating effect for them and service users.

An unintended effect of risk management policy with the intention to provide safety for service users and access to care for family and social service agencies has resulted in an emerging discourse of accountability. At play is the technology of responsibilisation which, according to Foucault (1997b), is a strategy to install at individual and organisational levels a type of responsibility deflected onto others in order to restrict liability on the state. In tandem with responsibilisation is healthism. Healthism, a technology of the self, highlights that through normalisation and experteeism, professionals require those who use services the need to work on daily habits, controlling impulses and increasingly, to take up the *freedom* to choose healthy behaviours (Foucault, 1997b). Self-care and self-management technologies can result in further dividing practices. Social development discourse positions crisis workers as expert agents enforcing responsibilisation and the police as *compassionate warriors* (Lurigio & Watson, 2010). Furthermore, this objectification of a person in crisis results in increased isolation and a discourse from service users of abandonment in times of uncertainty.

An overwhelming sense of abandonment, which increased loneliness for most of the service user and family participants developed within fractious relationships during times of crisis. Juliette, a service user, described how in the past, when she first started experiencing distress she became more and more isolated from people she knew. She said:

> *"My mum was away and they* [the crisis team] *put me on home based support, so I was staying at my uncles place and the support worker was there, but she wasn't really clued in and I was just climbing the walls, she would ring every so often and I would hear her saying – she is very controlling or she's doing this or that* [to the crisis team]. *I was scared to go to a crisis respite house... but the down side of being with my uncle was that I was, you know, pretty crazy and I felt like really embarrassed afterward because of all the stuff I had done and that kind of affected our relationship,*

kind of quite a detractor, but I just couldn't find anywhere I felt secure or felt good" (p.2).

For Juliette, a discursive construction of uncertainty exists not through a lack of people present in the crisis world but rather, a lack of security and presence within relationships with others and the self. Family and partners fed into the perception of being alone by being withdrawn from support networks to institutional interventions such as a crisis respite facility or the mental health ward or their relationship turning into surveillance and control.

Cindy, a family participant in her early 50s, had what she described as a *lifetime* of supporting people with mental illness. Cindy's mother had experienced *breakdowns* since she was a young child and had spent many years in institutional care. Cindy also described marrying a man who was violent toward her and an *alcoholic*, but her story below is about being a carer to her son Glen, who at age 18 had his first contact with mental health crisis services. Cindy found herself perpetually involved with services but at the same time feeling completely abandoned in her role as a caregiver. She stated:

"Because my son would not admit that he was unwell, he saw nothing wrong with what was happening to him and it's taken all this time for him to admit that he has a problem…he was fighting it, and it was the opposite with my ex-husband, they put him under the act and then took him off because he always was well presented but he was terribly abusive to me, and they thought nothing was wrong with him, so he got off the act quickly, whereas my son, he was so unwell and he resisted help, and so now after many years he has only just come off the act. Anyway, no-one ever asked me how I was coping, no-one ever noticed that I wasn't" (p.8).

Emily, a service user, suggested also that despite all sorts of mental health professionals looking into her life, telling her what she had wrong with her and what she could do to manage, her voice was not heard and she felt alone and somehow to blame. She said:

'No information was given, nothing was given to make me feel like I could understand what was happening…what had brought me back here, there was

no work done with me as to why I was a repeat offender. Why was I a repeat returner or something you know, no one sat down and talked to you, it was so lonely, that's the thing I can remember is the loneliness of the whole thing" (p. 4).

In the experience of accessing services the participants described a social development discourse, which privileges crisis workers as experts in their lives and results in a pathologising of their experience. Strategies such as case management and HoNOS within a social development discourse require nurses to adhere to the technology of responsibilisation and frequently this accountability is delegated to family members. By labelling people in crisis with a psychiatric diagnosis it can open up spaces for the person to receive help, however it is also the gateway to a raft of practices and techniques, which may contribute to further trauma and disability for the person experiencing distress (Busfield, 1996). Service users and family report inconsistency in the practice of crisis workers, and an unintended effect of policy and law further marginalising and excluding them from the help they expect. Furthermore, due to the positioning of crisis service as experts in people's lives, participants find more fear than care and the potential to gain skills and confidence the experience of uncertainty is overridden by being *managed* as a risky case within the discourse of social development.

6.6   Summary

This chapter focused on exploring crisis as an event in the lives of service users and families. Objectification of the participants has been explored through Foucault's notion of bio power. Within bio power the process of dividing practices and descending individualism take place. Individualisation of service users and families occurs through normative judgments used to assess and monitor the actions and attitudes of people according to an average or norm so that people in crisis undergo an experience of being silenced as a result of accessing services. Objectification of services users is achieved through technologies of the self such as responsibilisation and healthism. Accountability and social development discourses position those involved to act as they are told or being directed to.

In the next chapter titled *framing transformative action,* I present data from all participant groups including nurses, service users, families and the police to

provide an argument which contests who is the expert in the experience of a mental health crisis. The discursive construction of expertise rubs up against a competing discourse of personal recovery to create a discursive construction of uncertainty in the experience of crisis intervention. Chapter seven completes the presentation of data and analysis by focusing on the relationships involved in crisis intervention and Foucault's notion of ethical work on ourselves.

Chapter seven: Framing transformative action

7.0   Introduction

The previous two data chapters have provided analysis informed by Foucault. Foucault's analytical framework provides the opportunity to consider how certain discourses shape and influence the ways in which people involved in crisis become subjects of specific forms of knowledge/power. Thus far in this thesis I have developed an argument that objectification of people involved in crisis intervention involves the process of dividing practices and descending individualism. Individualisation of service users and families occurs through normative judgments used by services to assess and monitor the actions and attitudes of people according to an average or norm and results in people being silenced in a context of distress and uncertainty.   Objectification of services users is achieved through technologies of the self such as responsibilisation and healthism. Furthermore, accountability and social development discourses position those involved to act as they as they are told or being directed to.

In this chapter, theories that Foucault developed later concerning technologies of the self and ethical work on the self are utilised. Best and Kellner, (1991), Cheek and Porter, (1997) and Williams, (2005) have debated the idea that genealogical analyses of disciplinary techniques, as undertaken in the previous chapters are pessimistic, offer few prospects for social change and portray individuals as unable to accomplish successful resistance. To answer these critiques, this chapter provides analysis that informs potential transformation. An elaboration of ethics in relation to crisis intervention refutes such pessimism, by highlighting through data the opportunities that each ethical actor involved has to consider uncertainty and embrace transformative action.

Analysis and discussion in this chapter focuses on the discursive constructions of expertise and uncertainty to argue the need to counter *conditional citizenship* (Hamer, 2012) for people involved in mental health services. The end of this chapter sets the scene for the final discussion chapter on the work that each of us could benefit from in an ethical project of crisis care. In the final chapter I offer some suggestions about how the people involved in mental health crisis might utilise uncertainty and undertake transformative crisis care as an ethical project.   The

intention is a potential starting point from which those involved could begin to establish their own self-knowledge and conduct. By the terms self-knowledge and conduct, I am referring to a Foucauldian theory concerning *care of the self* (Foucault, 1990).

7.1   What happened to the plan?

The radical reform to mental health legislation and policy since the 1990s has in many ways reduced the inclusion of people experiencing a mental health crisis to a technical matter or problem of resource distribution. A discourse of accountability deflects attention away from services responsible for providing access and choice in treatment. Furthermore a dominant biomedical discourse in tandem with one of social development has led to general inertia in which the idea of recovery is called into question as possibly too idealistic. Clinical recovery policy in mental health emerged in the early 2000s and replaced the concept of psychiatric rehabilitation, which had come to be viewed as outdated and socially excluding for people accessing services. Psychiatric rehabilitation was problematic because in practice it related only to institutional care for those deemed mentally ill. This construction of service provision or mode of service delivery no longer accounted for a shift to provision of services being primarily community-based and significant changes to mental health policy underpinned by legislation and the intention of a *least restrictive environment* (MHA, 1992).

Evidence to challenge the dominant biomedical discourse does exist and by exploring the *contemporary limits of the necessary* (Foucault, 1979), alternative discourses less tied to the use of invisible power, can be made visible. Alternative discourses such as that of personal recovery outlined in the contemporary mental health policy schedules (MoH, 2005; 2008b; 2012a/b), is one example of resistance to traditional psychiatry. For some however, personal recovery has been another measured strategy to require the subjects of mental health crisis to biography their own narrative of personal identity and become excluded from collective resources that people outside of mental health crisis might be privileged (Mind, 2011; Perron et al, 2010; Sayce, 1999).

The key concept of recovery, defined by the Mental Health Commission as "people living well in the presence or absence of symptoms of mental illness" (MHC, 1998, p.3), is suggested as a goal throughout the policy documents. The concept of recovery, which is widely debated in mental health literature, suggests knowledge and skills required from mental health nurses working within crisis services. Guided by the MoH (2008b) recovery competencies: *Lets get real: real skills for people working in mental health and addiction* and Te Ao Maramatanga (The NZ College of Mental Health Nurses Inc), crisis nurses are seen to facilitate recovery services when they:

- Encourage service users to take an active role in decisions about their care;
- Support service users to optimise their health status within the reality of their life situation; and
- Involve whānau and communities in the care and support of service users (NZCMHN, 2012).

The changes to service configuration and demand for differing practice orientation of crisis nurses as outlined in the previous chapters, has occurred within a particular time in history. In this period of change from the 1980s, evolving mental health policies now emphasise service user autonomy and action. Although policies and legislation continue to shape professional interventions and envisage that services be recovery focused in order to be ethical, a potential consequence of policy change has meant a shift to an individualisation of risk. This shift involves service users of crisis mental health care becoming vigilant about their own recovery and obligations toward others.

Technologies of the self are facilitated with the distressed person or person requesting intervention, to *enable* them to see where and how things might be brought *back into the realms of normality* (Mills, 1995). Technologies of the self according to Foucault are:

> [m]odels proposed for setting up and developing relationships with the self, for self-reflection, self knowledge, self-examination, for deciphering the self by oneself, for the transformation one seeks to accomplish with oneself as object (1994, p. 29).

Technologies of the self are produced through training in self-scrutiny, evaluation, self-regulation, including learning to control the body, speech and movements alongside obedience toward the expert's advice. In the context of crisis services,

technologies of the self are produced in risk assessment and case management (Holyoake, 2013).

Clinical recovery orientated policy starts with a premise that people in crisis have a right to participate fully in the community and its institutions and implies that others involved are obliged to focus on the preference and goals of those who access services. In order to address immediate needs of people and prevent further distress removal of barriers is necessary. Barriers such as stigma and discrimination, referral criteria, inconsistency in approach and an over reliance on diagnostic practices and pharmaceutical interventions convey a message to service users and families that they are defective.

Two predominant changes have occurred since 2006 regarding the mode of access in a move toward "Accessible and service user friendly services" (MHC, 2007, p.2), these are provision of crisis respite/home based support and 24 hour access to a free-call mental health help line. Julianne, a service user, described initial relief when she was offered support to stay home rather than admission to hospital, however it was not what she was led to believe would happen, she stated:

> *"I was looking for some acknowledgement of what I was going through and some support but if you rang the mental health line they'd say have you taken sleeping pills? I'd say I can't sleep or whatever my complaint was, they'd be like have you taken sleeping pills, well go to sleep, and don't call us kind of thing, it was kind of like they just wanted to get off the phone for the next call, that's what it felt like"* (p.4).

Marie, a service user, expressed that she didn't want to go to hospital and was scared of the idea of others being around to witness her distress. However rather than staying at home being a comfort she described the experience as more of an invasion. She said:

> "*What I found quite hard is that they have about 10 staff who are rostered on just randomly in HBT* [home based treatment] *so you can have a different person each time which I felt kind of disconcerting having to meet all these new people. It felt like they were spying on me and even though they were friendly I was careful not to say anything that would end up with me in hospital"* (p.4).

On crisis respite, a facility in the provision of home-based treatment, MHN Barry noted that whilst non-hospital accommodation was often a preferred choice for service users and families the availability of such accommodation and quality of care was questionable. Carpenter, Falkenburg, White and Tracy (2013) state in a systematic review of the effectiveness of crisis resolution and home treatment teams, that evidence to support services is scarce, although they appear to contribute to reducing admissions. Crisis respite [in some areas these are short term beds in non-government agency supported accommodation or local motels] was a middle ground option. MHN Barry said:

"If someone is talking suicide, whether that's out of despair or frustration and indicating they are not able to prevent something happening then its unlikely that family will have them at home…or if someone is suffering psychosis and agitated with that disorganisation then it would seem reckless to send them home if they need constant supervision…next step is crisis respite which is not 24 hour supervision but increased, next step is the Act and locking them up" (p.12).

Violet, a MHN expressed that the few crisis respite beds in her District Health Board were often full with long-term service users who could not access supported accommodation. She was unsure of the usefulness of working in what she described as a remote supervisory role as the crisis worker, she said:

"We had a young girl in respite at a motel, there was a support worker and we told him 'she's got to be watched' and I was checking up on the situation by phone through the afternoon but the girl managed to make a serious attempt at trying to hang herself in the bathroom and the support worker was just in bits…trouble is, changing the venue doesn't mean any better care or outcome is going to happen – sure hospital can be stigmatising for people but at least there is the ability to monitor them and maybe do some work with them, in respite it's just 'watch duty' (p.13).

Introduction of a one point of access approach for all crisis services was rolled out across NZ mental health care from 2006 (MoH, 2006c). Free crisis phone lines offer a universal point of entry for anyone wanting to talk about their own or another's distress. The phone lines work on a process of triage, a component of a convergent

model of crisis intervention, outlined in chapter four. The person in crisis calls the 0800 line, speaks with a *trained mental health worker* who then decides on behalf of the caller what takes place next. MHN Carl noted that the introduction of the 0800 crisis line changed work life significantly, he said:

> *"We used to deal with people who rang up to say I've just broken up with my boyfriend and I think I'm going to kill myself...but now days the 0800 line deals with that type of nonsense, they tell them take a deep breath, make yourself a hot drink. And for the frequent flyers* [people who are long term service user who access crisis care after hours] *they get told big breath, make a drink, and take your medication... We only see people who self refer if we hear about them from the mental health line otherwise all our jobs come via another agency usually like ED, the police or supported accommodation and most people we see - we have seen before"* (p.22).

From a family perspective Cindy described the crisis line as more of a barrier in her experience. Family participant Cindy stated:

> *"When you're in the situation of being at your wits end and you make the call it's like dealing with the answer service that Inland Revenue has...push 1 if you're crying, 2 if you're mad, 3 if you are about to kill yourself – not literally but that's what it's like you feel screened out and just when you think you can get someone to help another door has to be opened...we are humans, why are they acting like robots"* (p.6).

Mol, Moser and Pols (2013) work on the implementation of telecare highlights that introduced technolgy such as an 0800 mental health crisis line can provide different sorts of care for those who use them. In the data from MHN Carl, the 0800 line is a nursing tool to inform the professionals about the *problem* so that they may tell service users and families what to do and it preserves his energy so that he can respond to external referrals rather than self referrals. In family member Cindy's experience, the 0800 line tells service users and families to hold onto daily life routines that professionals have designed for them and for her a dehumanisation of her need for involvement and engagement with the crisis service.

Rose argues that power is located loosely in institutions in which "self-activating citizens are enlisted to play a role in constructing and policing circumscribed zones of autonomy and freedom" (1999, p.166). An active-citizen is one who is expected to be a self-propelling agent engaged in the considerable work that being free to choose involves (Goggin & Newell, 2005). In the case of home-based support and crisis lines the people involved are called upon to be active-citizens and formulate choices about the *products* and services they receive. At the same time a discursive construction of services as experts (Foucault, 1988), or those responsible for service to the active-citizen, takes place. As crisis services are situated in clinical recovery oriented policy and legislation it's important to examine how being in crisis is socially constructed through a host of factors, including the ways in which it is talked about, the treatment that might be decided upon and offered, and how it is written about it. Discourses systematically form the objects to which they refer. Regarding *able-bodied keepers* as it is played out within a discursive construction of expertise, Foucault states:

> The space reserved by society for insanity would now be haunted by those who were 'from the other side' and who represented the prestige of the authority that confines and the rigor of the reason that judges. The keeper intervenes, without weapons, without instruments of constraint, with observation and language only, he advances upon madness, deprived of all that could protect him or make him seem threatening, risking immediate confrontation without recourse. In fact though, it is not as a concrete person that he confronts madness, but as a reasonable being, invested by that very fact, and before any combat takes place, with the authority that is his for not being mad *(1988 p.251).*

In short, the experience of crisis is not simply a matter of mental impairment or a psychological/emotional condition owned by the body. People in crisis become confined to a *space of unable* that is corresponding with a *space of unreason* (McCabe & Holmes, 2009). The social position to *liberate* people from psychiatric institutions to active-citizens living and participating the community has resulted in the creation of citizen activated mental health services. The current discourse of active-consumer driven services is a discourse of social development. Yet, as the data suggests people experiencing crisis are not *free* because their minds are subject to every increasing risk and accountability discourse, which many service users and families internalise.

This research reveals a clash of discourses between, on the one hand, service users own desires for making change within personal recovery (O'Hagan, 2008; Salzmann-Erikson, 2013) and, on the other hand communities including nurses, politicians and families, articulation of the service users' needs (Crawford, Gilbert, Gilbert, Gale & Harvey, 2013). Competing discourses create tension about how services are transformed to meet the needs of people and tensions are usually resolved by silencing the service user's desires with the noisy professionally based biomedical and accountability discourses.

7.2   Resisting exclusionary practice in crisis work

Within the micro-context of engagement between crisis nurses and service users clinical typecasting takes place. Through the use of technologies such as the clinical interview, the therapeutic relationship and risk inventories, nurses set about to gather information in their subject position as experts in lives of people experiencing distress. MHN Ross stated that the relationship in crisis is defined by the powers vested in the DAO in the MHA (1992), he said:

> *"When you set about to assess someone you always have in the back of your mind that the Act might need to be used…you can tell pretty much straight away that it's going to go our way if the person is able to speak about what they want as an outcome. For us there is so much pressure to keep people out of hospital and at the end of the day if we can get the family to agree to keep an eye on the person it's a win-win"* (p. 4).

Crowe (2006) suggests people are stereotyped when their power to disrupt or comply with the demands made on them meets the practical arrangements of the services in which they are located. Within the process of becoming to *know* the services users, the categories are constructed (Cutcliffe, 2000). This has the effect of establishing service users as subjects required to participate in technologies within biomedical and accountability discourses and offers the nurse a role in which to mobilise their technical knowledge and desire to meet the needs of the organisations in which they work (Cutcliffe et al., 2013; Homes et al., 2008; Shanley, Jubb-Shanley & Latter, 2003).

The processes of normalisation dominated nurses' accounts of their relationships with people in crisis. This was underpinned by a conviction that in doing so, they can work alongside service users and families in a therapeutic-holistic manner rather than constituting them as objects or *jobs* specified in a clinical identity (Rudge & Holmes, 2010). Nursing accounts of *holistic work* were nominal and in most cases the focus of the therapeutic relationship was the nurses themselves however, it is not that simple. Despite the aspiration to work in a way that used a therapeutic relationship the nurses were positioned themselves by the dominant discourses. This is particularly at play in crisis services where the implementation of the service comes at the detriment of having a therapeutic relationship with anyone. As MHN Lucy states:

> *"Respect the individual, there's no two ways about it...even if you think they are mad or bad...I know my limitations, like I cannot stand paedophiles and I can say to my colleague 'I cannot see this person' I can make up my mind and that is not the person for me"* (p. 3).

Andy, a MHN, also argued that crisis nursing was in a key position to engage people in crisis holistically, however during our conversation about an example from practice he summarised his thoughts with the following statement:

> *"When you've been doing this job for a while you can decide pretty much straight away how things are going to go, I make it clear from the outset there is only so much we can do and let's face it if they are seeing us then not a lot else is working for them, so I say let's get on with it or move on"* (p. 13).

The dialogue from MHNs Ross, Andy and Lucy are in direct contrast to the principle of holistic care. Statements from the nurses about their intentions to *care* for people in crisis were frequently destabilised by their positioning to choose between either an obligation to the organisation or the therapeutic engagement. Perron argues:

> New 'personal' truths that can disrupt these 'truth games' can therefore emerge, simply by being aware: aware of the existence of such processes of self-formation, their effects, their reason for being, and their reason for disappearing (2013, p.158).

In addition, Foucault (1994) suggests that in order to live an authentic life, our ability to act in ways that are consistent with our beliefs and values, rests on *self mastery*. He describes self-mastery as our ability to exercise power over ourselves in order to govern ourselves in an ethical and truthful manner. Through self- mastery, care of the self can lead to action, which makes way for new possibilities such as experiencing the self in an autonomous manner. More exactly, in new ways that do not require us to be subservient to external authority or techniques, for example the *confession* (Foucault, (1988a).

One key technique used to position nurses in the role of expert in the lives of others is the technology of the confession (Richardson & Stewart & Destin, 2009; Winch, 2005). The confession is used as a term here according to the genealogy of confession as a technology of the self (Foucault, 1988a). Foucault emphasised the politics and ethics involved in questioning of the self, the use of caring for self and self-knowledge, or lack of self-knowledge, that are here seen to underpin the goals of a therapeutic relationship within mental health nursing. A binary of self-denial verses self-mastery is present at different points of time during crisis and so different technologies of the self are required and, in turn, enable different ways to constitute the self (Foucault, 1988b). The intent behind such analysis of self-mastery or self-denial is to attend to the ways that things can be different.

Historically, a view of self-indulgence or desire tends to be played down by people involved in crisis as it is viewed as somewhat inappropriate as risk to self or others has become known as the required focus within a discourse of accountability (Richardson, et al, 2009; Ambrosio, 2010). However, in the attempt to understand desires including for example, hopes, dreams and uncertainty of services users and families is the opportunity to acknowledge the bodily, the emotional and the relational aspects of life. Furthermore, attempting to understand desires may assist in questioning the motives for control and containment of people in distress. The therapeutic relationship within crisis care is one potential set of cultural practices where the nursing/confessional relationship becomes open to reflection and can unlock the possibility of change.

7.3   The therapeutic relationship, a confessional in crisis care – a history of the present.

Critically reflective crisis nurses not only ask how power within the therapeutic relationship constructs the knowledge of the self for himself or herself and service users, but also how the relationship can improve. Crisis nursing has the potential to develop in line with Foucault's ethics as a practice of the self and as a form of self-acceptance and mastery rather than one of self-rejection or denial. The ideas of Foucault regarding the personal and philosophical are entangled together (Hook, 2011). His critique opens up possibilities for us to sort out how we might see, understand and, in turn, negotiate our subjectivity and the power relations in the world of crisis intervention. Mental health nurses are part of a history of the present and need to pose questions or problematise the present of how potential issues currently experienced by service users, families and nurses themselves can be re-evaluated (Stevenson & Cutcliffe, 2006).

Genealogy challenges the humanistic idea that the self is unified and clearly understood (Rose, 2007). It also challenges the Enlightenment agenda by highlighting disparity, difference and the taken-for-granted universal *truths* about life (Foucault, 1977). Foucault argued that the body has become both an object of knowledge and a site where power is exercised, but he pointed out forms of subjugated knowledge that exist in any disciplinary network of power relations. By recovering these subjugated knowledges within crisis intervention there is potential to harness alternative ways to speak about uncertainty and challenge the dominant stories of deficit, which create inertia.

In Foucault's earlier work he conceived the relationship between the subject and *games of truth* in terms of coercive practices, for example, that of psychiatry or theoretical-scientific discourses, analysis of living beings. His later writing, changes from an emphasis on games of truth not as coercive practices, but rather as an *ascetic practice of self-formation* (Rabinow, 1997). Foucault argued that ascetic practice is an "exercise of self upon the self by which one attempts to develop and transform oneself, and to attain a certain mode of being" (Foucault, cited in Rabinow, 1997, p.282). This particular work of ascetic practice suggested by

Foucault (1982), challenges the Kantian practices of freedom, which was critqued by him problematic as it involves essentialist and universal propositions. Foucault argued that the notion of a hidden self or inner nature that has been imprisoned and seeks freedom can no longer be seen in solely negative terms. Rather, freedom must be rethought to involve more positive notions of autonomy and the freedom of the individual to construct new modes of subjectivity (Rose, 2007). Foucault historicised such questions of ontology and argued that there is no such essence of self, only becomings and the forging of an identity through a process of self-formation (Foucault, 1997b).

One such process of self-formation through the technology of the confession is the telling of *truth*. Rehu, a service user stated:

"I tried to listen a bit more about what they [crisis team] *were wanting me to say, when they finished talking to me, I went inside and my brother was crying real hard, he said please just get the help and be honest about it you know, tell them how you really feel, tell them properly, so I have this time, I have to"* (p.4).

MHN Ross, stated that a truthful account from service users was essential to their assessment of safety, he said:

"We need to get the truth of what's going on, I've been threatened in this job, we are exposed to it all the time in this work but when it comes to the fact that someone is going to kill themselves how are we meant to know if they don't tell us, I always ask people 'can you guarantee' your safety" (p.13).

Facilitation of *truth telling* occurs in the therapeutic relationship as nurses engage with people through technologies such as mental state assessments, telephone counselling, monitoring or observational practices to elicit information or disclosure about personal problems occurring (Bentall, 2004). Whilst the intention of nurses is to assist the person to express and manage their distress, the process has a contradictory effect of dampening the desires and needs of people experiencing crisis. In Western societies, the confession is a deep-seated cultural practice, which

involves self-disclosure and acknowledgement of weakness, fault or wrongdoings, an account of one's actions and private feelings (Theodosius, 2008).

In confessing the self, service users require an audience that will hear, understand and potentially judge and provide consequences to their stories. In the process of crisis intervention service users, families and nurses reveal part of their identity and enact plural roles such as recipient, witness, accomplice, mediator, judge and enabler (Graham, 2010).   Service user participant Theo stated:

"I was in pretty dire straits, they [crisis team] *had to judge because I wasn't in the right frame of mind to make an opinion and I was handled probably the best way given the way I was posing such a problem for them"* (p. 2).

Family too is involved in the confession and subject to the consequence of their account as Rosemary, a family participant states:

"We had to get used to the awful truth that Darren had schizophrenia" (p.1)

And later in our interview:
"In the beginning the crisis team were quite understanding and believed me... then he [the son, Darren] *would come off his medication he got very ill again they willingly let him in and they kept him there until he was well...but things have changed now, it's like they don't believe me or they think it's up to me to make him behave, as if he is putting it on...why do they think Darren could put on being a schizophrenic, do they think I make him like that? Sometimes I am made to feel like I am going mentally ill myself"* (p. 3).

It is plausible then that hesitation may exist in the act of confession, whether to reveal the self to others or the desire to keep things private or hidden. Technologies of the self, such as the confession, are suggested by Foucault as:

> [t]he various operations on their own bodies and souls, thoughts, conduct, and way of being that people make either by themselves or with the help of others, in order to transform themselves to reach a state of happiness, purity, wisdom, perfection or immortality (1988a, p.19).

Furthermore, he suggested that the ancient Delphic principle of *know yourself* became dominant over time and took precedence over *care of the self*, thus legitimising concern with oneself and requirements to work on self-improvement (Foucault, 1988a). It is plausible then that hesitation may exist in the act of confession, whether to reveal the self to others or the desire to keep things private or hidden.

7.4   Uncertainty can involve loss and gain

Having highlighted the tensions created by competing discourses, removing barriers to recovery orientated crisis intervention entails attitudinal and structural change and a fundamental shift way from deficit-orientated thinking that has for so long driven mental health practices. The accounts of people experiencing a mental health crisis highlight forms of transgression against identities and experiences that their families, services and others impose upon them (Sayce, 1999; Pilgrim & Tomasini, 2012; Graham, 2010). Juliette, a service user, noted in her first experience with crisis services that points of resistance were apparent, she said:

> *"I realised no one was listening to what I needed and the angrier I got the less people wanted to be around me, I knew I wanted help and I began to realise the way I was asking for it wasn't working…so I started listening to myself and what I wanted to be different"* (p. 3).

During an interaction with the police, Lisa, also a service user, realised she was cast in a role of public nuisance and saw this as a turning point to gaining some control over her life. Lisa said:

> *"Quite a few like four or five police had arrived then the sergeant came in and said because they were aware of my history he came along to offer some sort of guidance I guess and a bit more life experience because these two younger cops were just thinking oh you know 'she's just nutting out' they didn't know the more subtle things that were going on and he did, so he basically sat down with me and just talked, kind of talked me down and was quite caring…I realised after they left that I didn't want to be involved with the police for that*

purpose, I wanted to be able to talk about how I felt with people I choose to be around, ones that will accept me for who I am and let me work through what I need to do to make sense of it all" (p. 4).

Family data also demonstrates distinctive understanding of crisis, and of the conditions required for fair dealings in their key role as caretaker in crisis intervention. Katie, a family participant, suggested the ability to be available without policing her sister led to a better outcome for all. Katie said:

"It's so hard in those times it really takes over life and when I think about it you are really left alone to just deal with it because once the crisis team finish their visit you are stuck with the person and it takes ages, feels like forever before things start getting better. I worked out that I didn't need to know how to fix it, that I could roll with the situation and just be there for her in a way that encouraged her increasing confidence. I realised also that I wasn't in control of the situation and for [name of sister] to manage better she had to be given the opportunity to make choices and learn new ways of dealing with it" (p.7).

Family participant Chris also described how he had rethought his role as gatekeeper to accessing services and policing his partner's symptoms of distress, he said:

"[Name of partner] *has been struggling for years, we all have, and in that time a lot of people in our lives have become distant because they couldn't cope with it or we couldn't bear them being round to see some of the goings on, I used to push them away to protect us both...but now the family have come back into the fold, I think that's really helped, it's really helped me see it's not up to me alone...I can be a part of a support network, and share the good with the bad, now I've stopped anticipating life going wrong and beginning to enjoy again everyday life"* (p.7).

In regard to transforming as a family support person and parent, Tony stated:

"When Troy's baby came along I remember saying to him, it's not just about you anymore, there is someone else in your life...I realised I had been grieving for a son that didn't turn out like I expected, but that's the thing about being a

parent, at some stage we all have to recognise our kids become adults and take their own pathway" (p.13).

In a study comparing perceptions of personal loss experienced by families due to mental illness of a child or loved one, Stein, Aguirre and Hunt (2013) highlight the importance of working through issues of disruptions and access to social resources in the context of family life with both service users and families experiencing distress.

The positioning of family as gatekeepers of crisis intervention can be understood to operate within a micro regime of governmentality (Foucault, 1991b). The micro regime of gate keeping operates as a set of unwritten rules of conduct and sanctions or prohibits certain actions. Ambivalence, uncertainty and an expectation of change to occur may well be a point of resistance to lessen the isolation felt by service users as well as transforming for families, their role to support person, rather than *burdened carer* (Barnes, 2012).

Family accounts of crisis contrast with the professional needs-driven discourse (Zegwaard, Asrtsen, Grypdonck & Cuijpers, 2013) but they do not necessarily hold a positive view of recovery (Stiles, 2013). Families and service users verbalise their experience of crisis as a struggle with uncertainty in which recovery may be a possibility, but only if everyone involved begins to recognise the existing exclusionary practices.

7.5   New access to crisis intervention

Differing personal, social and institutional discourses inform the experience of crisis and the response by others. Crisis intervention as a practice implies some type of interaction between people, which is informed by their perception, personal experience and for clinical staff, a theoretical perspective. Theory is formed by a wide conceptual premise, which informs a particular subjectivity or way of seeing the world (Powers, 2013). Nurses in this study use certain frameworks or approaches that are largely informed by the political constraints in which they work. However the frameworks are not necessarily underpinned by evidence based crisis intervention theory.

Blanket implementation of statutory roles and responsibilities during the introduction of the MHA (1992) was, in an overnight fashion, imposed on mental

health nurses working in community settings (McKenna et al., 2009). Whilst new access to community oriented services opened up the opportunity for choice driven, citizen-activated interventions in the discourse of social development, attention to the complex relationship between those who present in crisis and the response to the event has been minimal. Perceptions and responses are significant variables and require interrelated agreement and actions to make change and create a new vision for citizen activated services.

Blueprint II: part one, *How things need to be* (MHC, 2012a) portrays an intention to "champion a bold new vision to improve the mental health and wellbeing of all New Zealanders" (p.6). Blueprint II a twofold, ten-year political vision, highlights the need to recognise and respond early in the event of a mental health crisis. In the executive summary of *How things need to be*, it states: "Mental health and wellbeing is everyone's business. The stage is set for a future where everyone plays their part in protecting and improving mental health and wellbeing" (MHC, 2012a, p.6).

This new policy highlights a discourse of personal recovery in the collective efforts of self-governing citizens. Part two of Blueprint II is *Making change happen* (MHC, 2012b). This document is an action plan to implement the policy outlined in part one. The now disestablished Mental Health Commission states:

> It is widely accepted that everyone is responsible for mental health and wellbeing. It is the only way individuals and their families and whānau can improve their ability to weather adversity and to achieve their own aspirations. At the same time, we need to greatly expand access to services by doing things differently and making the most of all our collective resources (MHC, 2012b, p.3).

There are five key *directions* outlined in Blueprint II *(see figure 6).*

Figure 6: Key directions for urgent mental health service access

1. Respond earlier and more effectively
2. Improve equity of outcomes for different populations
3. Increase access (no wait policy)
4. Increase system performance and use of resources
5. Improve partnerships across the whole of government

Source: Blueprint II: How things need to be: directions for future MHS (MHC, 2012a)

All directions outlined in the document would in the most part, be supported by participants in this study, as MHN Violet summed up in regard to new initiatives to faciliate better access for people in crisis:

"It's a matter of getting onside with all the people involved, it's about listening to what they want" (p.9).

Service user Theo, in terms of his own crisis management, would concur, he said:

"At the end of the day if we speak up about what we want and we do it together, then anything is possible" (p. 7).

New policy provides support to the discourse of personal recovery and offers the opportunity for government run organisations to be directed to transform institutions and practices. However, family participant Tony cautiously points out:

"I've been a family rep on those committees that are trying to make change, years of work. But at the end of the day, you can't change a culture of mental health care by putting a new cover on the book" (p.8).

Lastly, MHN Carl's take on implementation of new policy and guidelines within practice – he states:

"Yer, I've looked at the policy, the guidelines the truck load of new paperwork saying what we should do differently – quite frankly, its bullshit" (p.18).

Haycock-Stuart and Kean (2013) warn that the current *top down approach* to policy implementation within community settings encourages resistance in frontline nurses rather than commitment. When nurses speak up against new policy implementation a process of individualisation can occur. Individualisation is related to a deviation from the norm and can be viewed as negative or undesirable and potentially a divergence that needs correction (St-Pierre & Holmes, 2008).

Blueprint II (MHC, 2012a/b) may well be offering further dichotomy in the notion of dependency creating mental health services and that of self-activating citizens. A discursive construction of expertise whereby service users and families are *free to choose* the timing and venue of intervention, as if they are being handed a menu, strengthens the idea that the self-activating citizen rightly takes responsibility

for their own health needs and activates services to assist only if or when required. The dichotomy however lies with the menu of choice.

Crisis services are argued in policy to provide the least restrictive and least dependency creating interventions to promote resilient and self-determining individuals and families. However as I argued in chapter five and six whilst this serves to increase access, the discursive practice of labelling people as *risky* within an accountability discourse and the privileging of *expertise* within a social development discourse, translates to inaction. These discourses subjugate those of personal recovery resulting in the silencing service user's desire to make change in the discursive construction of *uncertainty* and contribute to the discursive formation of *conditional citizenship* (Hamer, 2012).

7.6   Summary

Some authors suggest that genealogical analyses of disciplinary techniques are pessimistic, offer few prospects for social change and portray individuals as unlikely to resist successfully. By utilising later developments in Foucault's theoretical ideas concerning ethical work on ourselves, pessimism is refuted, by highlighting through data, the opportunities that each ethical actor involved has to consider uncertainty and embrace transformative action. Analysis and discussion in this chapter focused on the discursive constructions of expertise and uncertainty to argue the need to counter conditional citizenship for people involved in mental health crisis intervention.

The end of this chapter has set the scene for the final discussion chapter on the work that each of us might consider regarding an ethical project of crisis care. In the next and final discussion chapter, I offer some suggestions about how the people involved in mental health crisis might utilise uncertainty and undertake transformative crisis care as an ethical project. The intention is a potential starting point from which those involved could begin to establish their self-knowledge and conduct.

Chapter eight: Discussion and concluding comments

8.0   Introduction

This thesis thus far has focused on analysis of the formation of certain regimes of truth (Foucault, 1990) in relation to mental health crisis intervention. Functioning through circular relations of power-to-knowledge and knowledge-to-power, the key discursive constructions of mental disorder, risk management, expertise and uncertainty have centred on a tension between normalising and pathologising practices by those and to those involved in the study.   Tensions between normalisation and medicalisation of mental health crisis are political practices involved in the access and delivery of services. Nurses suggest they want to practice in ways that authentically and ethically engage people in a situation of crisis but say they cannot as they are required by the dominant discourses to be risk adverse; and attempt to control the actions and behaviours of service users and families to best meet the economic needs of the organisation. Dominant discourses exert considerable surveillance and responsibility on service users, families, mental health nurses and interrelated organisations such as the NZ police.   By problematising crisis intervention in this thesis, a variety of possibilities for understanding and helping in times of distress are uncovered through consideration of emancipatory action with the aim of the preservation of human dignity to remove barriers to social justice.

This chapter begins by revisiting the research aims then reviews and summarises the findings of this study. The resistances that occur in crisis services are argued as an ethical project in which all concerned have responsibilities. The chapter summarises the key converging and competing biomedical, accountability, social development and personal recovery discourses within crisis intervention, in order to disrupt structural systemic inequities. Following this I argue that self-reflection is required in order to attend to the ways one's experiences affect and contribute to maintaining the status quo, by presenting the various potentials for resistance surrounding the dominating discourses. The last section highlights the opportunity for building authentic relationships within crisis intervention. Foucault's framework of ethical practice is suggested to provide potential resistance to counter *conditional citizenship* (Hamer, 2012; Isin & Turner, 2002) and redefine

responsibilities in the field. At the completion of this chapter, I present the limitations of the study and put forward suggestions for future research in this discursively constructed field.

8.1   Revisiting the aims of this research

Disciplinary knowledge is put forward in mental health care as empirical, scientifically advanced and argued to be valid in favour of alternative interpretations of human distress. The disciplinary and institutional factors that influence and shape the experiences of those involved in a mental health crisis also constrain the voicing of diversity and complexity of the experience. As I stated at the beginning of this thesis, I was convinced that if this study was to offer something different to develop mental health crisis care I had to move beyond a humanistic position of subjectivity. My decision was informed by Foucault's genealogical theories so that I could examine how power and the people involved constitute themselves as subjects, acting upon others and acted upon, in particularly regulated ways by others (Foucault, 1982). I was concerned with problematising how those involved in crisis intervention seize or become seized by subject positions within scientific, economic, social and public discourses.

The utilisation of Foucault's theories and the methodology of discourse analysis informed and shaped the research question and aims of this study. Use of discourse in this study is a philosophical term, referring to the perspectives and knowledge, within epistemologies that legitimise certain ways of acting or being. Foucault's discourse theory views knowledge as all kinds of contents which make up consciousness or kinds of meaning used by historical persons to interpret and shape surrounding reality. As noted this research aligns with a principle that people gain knowledge from the respective discursive context into which they are born and in which they are involved throughout their lives (Foucault, 1990).

An overarching aim of this project was to explore and critique dominant discourses involved in mental health crisis. I intended to open up the networks of power and knowledge that support and legitimise them, to make way for resistant discourses that speak about crisis intervention in alternative ways. My aims of this poststructural research project were to develop a discussion as to what are the converging and competing discourses, strategies and technologies involved in the

field of mental health crisis intervention. The first process I used was to consult with service user and family organisations to develop the research proposal; this process is detailed in chapter three. Following this I undertook document collection over a six-month period whilst working one day a week in a DHB crisis intervention service. I sought the perspectives of crisis service users, families, mental health nurses and later the police by undertaking individual interviews. Analysis of research and grey literature took place in between interviews, data analysis and during the writing process. The last phase was the development of a position to discuss a range of converging and competing discourses concerning crisis intervention, the production of this thesis.

In this chapter I revisit the main findings of this project and summarise some of the vital arguments that developed from the findings. The main theoretical and contextual ideas within this thesis are discussed in regard to the complexities of crisis intervention and the various discourses that are dominant, yet interrelated, so form discursive constructions. Examination of the converging and competing discourses of crisis intervention follows in an evaluative outline. The discursive constructions within crisis intervention are presented as a diagram *(see figure 7)* to demonstrate the associations between discursive constructions and the underlying discourses, strategies and technologies. The purpose of the diagram is to introduce the breadth of discussion and maps the analysis.

8.2   Problematising structural systemic inequities

A desire to make change in a situation of mental health crisis is largely underestimated by all involved and at times impaired by access to and allocation of crisis intervention resources. Instead of considering new perspectives of coping and facilitating useful interventions for people in distress, services subject users and families to regimes of pathology and normalisation in a counter-productive subjection to maintain discourses of biomedicine and accountability. It has been argued that the deeply personal and highly productive experience of mental distress has come to be produced as pathological, individualised and ultimately a negative and costly burden to the self and community. Alternative interpretations of embracing change and resistance in the experience of crisis is dominated by reconfirming the necessity of state power over its people but with new

responsibilities for those involved, to liberate oneself from the distress and the interventions on offer (Perron et al., 2010; Sawyer, 2008). Consequently, biomedical and accountability discourses have converged and are further strengthened with a social development discourse that results in subjugation of personal recovery discourse.

Figure 1: Discursive constructions within crisis intervention
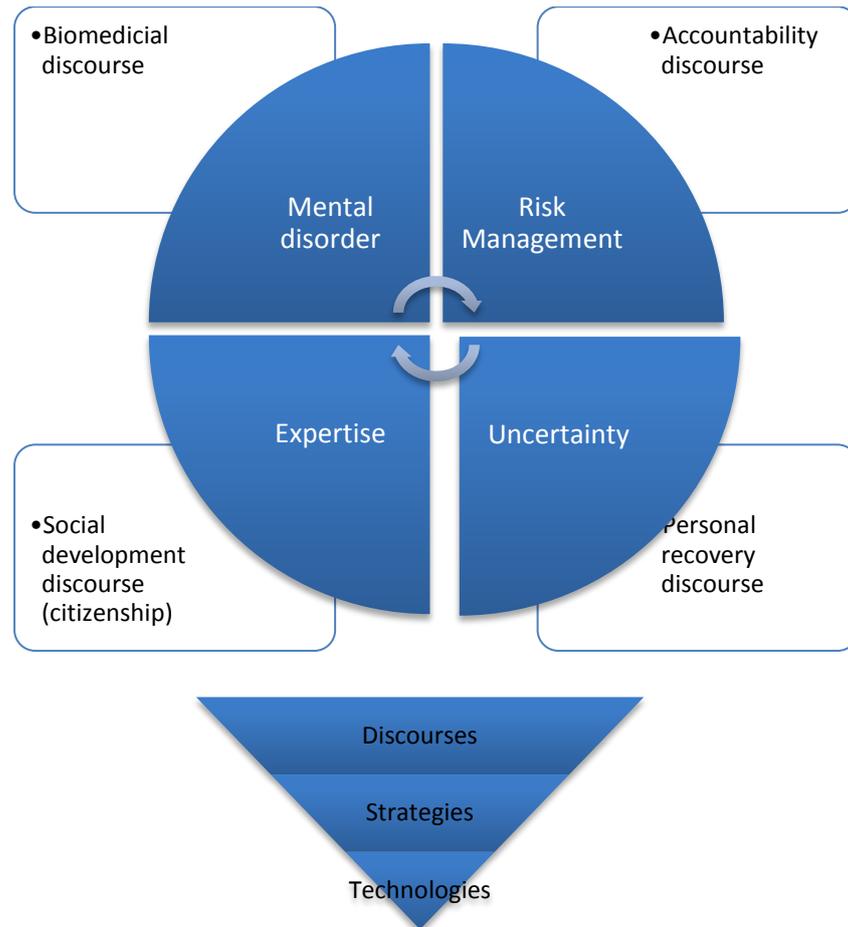
Discourses	Strategies e.g.	Technologies e.g.
Biomedical	DSM V; psychopharmacology.	Mental state exam; medication monitoring; diagnostic imaging.
Accountability	Mental Health Act; other related legislation; mental health service specifications.	DAO role; triage; risk assessment; free crisis line.
Social development (citizenship)	MHC policy; case management models.	MHSMART; HoNoS. WRAPS; choice appointments.
Personal recovery	Service user activism/consultation/organisations.	Peer support; enduring power of attorney; no force advocacy.

In order to unsettle these truths about crisis intervention and open up possibilities for thinking and acting in potentially more helpful ways for those who desire change, there is a need to highlight the contingency of contemporary thoughts and practices. The first part of this thesis presented a literary history in order to map out a historical context of crisis intervention. Chapters one, two and four, provide discussion as to what has evolved given the political, social and scientific context in which claims for the need to act on another person's experience of distress have developed.

Chapter four brought together the context of how historical discourses of madness have converged with biomedical, accountability and social development discourses associated with people in crisis. I argued that imposing restrictions and surveillance on people thought to be experiencing mental illness is legitimised in a mental health system driven by politics and regulation. Analysis of crisis mental health policy and law, alongside participant data in chapter five, showed how biomedical discourse is privileged and operationalised through strategies such as the DSM (APA, 2013) and technologies such as mental state exams that require an inventory approach, are reductionist to clinical expertise and only require that the clinician is able to identify deficits of people in crisis.

Practice models of crisis intervention opened up the possibilities of new access and timely interventions to assist people in mental distress (Lapsley et al., 2005; MoH, 2005; Te Pou, 2012). Simultaneously a discursive construction of risk management driving access to crisis services and statutory roles meant that the front line staff and users of services engaged in a very different experience. In chapter five, I argued that examination of strategies within the accountability discourse such as the MHA (1992) and technologies, for example, clinical practice guidelines, highlight how those involved are constituted as subjects of specific forms of knowledge. Mental health survivors argue against violence towards people deemed mentally ill (Crossley, 2004; Minkowitz, 2006; 2010) and as demonstrated in chapters six and seven, participants in this study attempt to resist the disabling power of language and practices associated with psychiatric labelling within an accountability discourse (Mackay, 2011).

Risk management and the therapeutic interview are important technologies within crisis intervention (Cutcliffe & Happell, 2009; Muir-Cochrane & Wand, 2005). The associated exercise of surveillance through fear and threat have an unintentionally disciplining effect between nurses and service users and within relationships that nurses have with colleagues and others (Hannigan & Cutcliffe, 2002; O'Byrne, 2008). A discourse of accountability co-exists with a biomedical discourse to create disciplinary mechanisms widely implemented by and on mental health nurses. The dominant accountability and biomedical discourses demonstrate how power, surveillance, and disciplinary techniques are used within crisis services to control and contain both human resources and costs (Holmes, Rudge & Perron, 2012; St-Pierre & Holmes, 2008).

In the first data chapter I argued that nurses working in crisis teams lack awareness of the mechanisms of persuasion and coercion they employ and are favoured by medicine and policy writers to achieve their goals. Through a review of the conceptualisations concerning technologies of the self, the nurse who takes up the subject role of the DAO (MHA, 1992) and enforcer of compliance (Holmes, 2001) applies themself to become an instrument of the biomedical and accountability discourse. Analysis of the conceptualisation of the subject, subject positions, subjectification and subjectivity provided an exploration of how and why the participants become objectified.

Objectification is through regulation of the participant's time, their actions and activities as they shape themselves into objects of instrumentality in the governmentality of crisis services (Powers, 2013). Moreover, a requirement to eliminate all that is mental health nursing from practice is a consequence of the productivity techniques used by mental health services. In the guise of patient safety, technologies such as MHSMART; case management and HoNOS are valued by the state as a means to measure certain types of productivity, however they are a technology of social development discourse and exist so that limited resources can be further restricted.

In 2000 the MHC launched a new recovery orientated mental health policy heralded as driving mental health services toward a new era of self-determining, personal recovery focused care, over the next fifteen years. In the next ten years a

strengthening of service user discourse about everyday distress and coping with illness took place. This was supported by public health discourse circulating to counter stigma and discrimination and social policy underpinned by a principle of entitlement for people experiencing mental illness. During the same timeframe of the early 2000s, economic discourses of budgetary restraints and viability of social service spending was taking place within NZ society. Many government institutions were under review and pending restructure as social welfare made a move toward social development through neoliberal discourse. Social development discourse has dominated NZ health policy since 2000. A key approach of social development discourse is the integration of economic and social policy argued to bring benefits of economic development to all citizens; and provide for social welfare that enhances people's abilities to participate in a productive economy.   Through social development discourse, governance of the people gives prominence to networks of government and non-government organisations as a distinctive means of coordinating economic and social activity. Alongside the shift of resources and power are established forms of hierarchies and markets. Therefore, delivery of services is less the prerogative of the state. Through the move to decentralise government responsibility, communities and service users become subject in, objects of and resources for the policy process.

Government agencies such as housing, income support and the justice system are also involved in the discourse of social development and often have a direct relationship with crisis intervention services. NZ police in particular have a relationship mandated through the MHA (1992) to provide assistance and transportation in the case of mentally disordered persons requiring assessment or return to treatment. Concurrently the police also have a public safety mandate under the Crimes Act (1961). Within the context of social development and accountability discourse the police experienced new regimes of government surveillance and public monitoring. Through the discourse of accountability the police position the person in crisis as object of mental disorder, which subjects the police to risk and liability. In order to shift liability of potential risk associated with people in crisis and to reduce use of scarce public resources, the police and other social service agencies have strengthened a discursive construction of expertise through a dramatic increase in referrals to them.

Discussion thus far has centred on the process of governmentality within mental health crisis services. Foucault's theory of governmentality demonstrates that through a network of everyday, taken for granted techniques and routines, order and control is exercised by subjects, which enables them to function as self-regulating members of the institution. As a result the creation and maintenance of service users and families who possess the will and the capacity to conduct themselves in accordance with the government objective of self-responsibility is maintained. However nurses in crisis teams speak of conflict and dissatisfaction toward biomedical, accountability and social development discourses. Nurses and people who access crisis services also act in ways that disrupt intended processes and outcomes of the dominant discourses. In the next section of this discussion chapter I argue the need for emancipatory action, an approach to crisis work, which is about avoiding the dehumanisation of distress in order to preserve human dignity and remove barriers to social justice issues such as equitable access.

8.3 Facilitating humanisation is a moral obligation of the nursing profession

In the provision and delivery of crisis services, particularly at the point where relations of power are exercised in encounters between nurses and services users and or family members, dominant discourses can be disrupted and policy subverted in pursuit of other objectives. An objective of autonomy or self-determination for people experiencing mental illness has been argued through the mobile and fragmented discourse of personal recovery from service users (O'Hagan, 2003) and socially inclusive practice from social theorists (Pilgrim, 2008). This section continues critical discussion on the range of converging discourses involved in crisis intervention and platforms a competing discourse of personal recovery and a vital discursive construction of uncertainty. The following discussion extends the analysis from data chapters five, six and seven of this thesis.

Policies such as clinical recovery (MHC, 2005; 2012a/b) and reduction of social exclusion (Prior & Barnes, 2011; Sayce, 1999) provide discursive power as meanings that are attached to individuals and social groups. However, policies are practical instruments for the administration of governance, they are not just discursive in their affects, they have material consequence for people in their everyday lives (Fassin, 2009). A formation of mental health policy creates specific

forms of practice that both enables and constrains the meaning that the policy discourse seeks to secure. Nurses describe uncertainties toward the dominant biomedical, accountability and social development discourses of crisis intervention. Service users and families want professionals whom they can trust to be able to do what is required. Therefore it is important to recognise that the links between strategies, technologies and discourses may not always be effective. In fact, the justification of a biomedical or accountability discourse may be ambiguous or even contradictory and connections that they make may contain gaps and inconsistencies (Bussolini, 2010). For example, a consumerist strategy deploying technologies of *choice* may be justified by a social development discourse, yet reducing access through a policy to adhere to diagnostic criteria is competing with a policy to encourage service users to identify the types of services they need. It is evident in crisis intervention practice that strategies and technologies are frequently underpinned by several different discourses that offer varying underlying principles for action. Uncertainty generated by conflict or inconsistency can open up the possibility for alternative forms of action to be developed (Foucault, 1994).

Practices of crisis intervention are made possible and shaped by a range of strategies/technologies and by the policy discourse that justifies those technologies, but practices are not just determined by those. Clinicians in a crisis team are human actors who bring with them a personal agency (Weedon, 1987), which effects their choices when deciding what to do and how to do it in an encounter of crisis intervention (Stoljar, 2011). An interaction between clinician formal strategies and technologies with their informal interpretation of the situation, such as past experience, local knowledge and their subjective, emotional response to the issue they are required to act upon, results in situated judgement about what actions to take.

The discourses playing in the field of nursing practice in crisis intervention are more than the application of an objectively considered selection of approved strategies and technologies. More exactly they are the result of an engagement between the nurses knowledge of, and skills in using, the various formal interventions and their understanding of the expected policy outcomes (Jacob & Holmes, 2011; Rudge et al., 2011). This occurs alongside their individual, context

specific, moral and emotionally charged assessment of certain needs and problems, including the likely impact of choices (Allan, 2012).

The specific context of mental health crisis intervention takes on additional importance as service users and families bring their own agency, or ways of acting, to the episode of assessment, or moment of policy delivery. Biomedical and accountability discourses seek to create service users as defined subjects of the discourse process and constructs certain subject identities for them within particular forms of governance, for example, sick, dangerous, compliant, mentally disordered, bad not mad (Federman, Holmes, & Jacob, 2009). Subject identities exemplify certain forms of agency in response to mental health policies (Powers, 2013), including characteristics that construct the service user as an active participant and partner of outcomes. However, service users and families are not *vacant lots* waiting to be inscribed with attributes and potentials prescribed for them by the biomedical, accountability and social development discourses.

Service users and families respond to and engage with crisis teams with their own understanding of the situation as well as their own sense of what constitutes a fair or unfair outcome. People who access services also respond with their own capacity for action, including alternative sources of knowledge (Felton & Stickley, 2004). Different understanding and capacity on behalf of service users and families made by mental health policy can introduce an uncertainty or a destabilising dynamic to the interaction with the crisis team. Therefore, a sense of openness about the process, potential outcomes and a negotiation of meaning are required.

The discursive construction of uncertainty and the extent to which this is experienced in the engagement or actions taking place within crisis intervention varies widely between different forms of governance. In the crisis situation the authority of the nurse is legitimated by legal powers and specialist professional knowledge that can place strict limitations on how far outcomes might deviate from those prescribed in formal strategies or technologies (McKenna et al., 2009; Rudge & Holmes, 2010). However there is evidence that nurses adjust their professional norms, bend legal or institutional rules and work toward alternative outcomes. Forms of governing that take place in crisis services are centred on discursive constructions of mental disorder, risk management, expertise and uncertainty. These

discursive constructions enable particular sets of strategies and technologies to take shape that are realised materially in policies and practices. Strategies, such as the MHA and mental health recovery policies that demand adherence to service access through the DSM and technologies, such as triage and risk assessment, shape and constrain the formal context in which nurses and service users engage in as active agents. However, nurses, service users, families and others are active agents during the encounter of crisis intervention. They all bring their assumptions and stance of subjective interpretations of context-specific meanings and their situated judgements about what action to take.

Despite specific strategies and technologies being definitive, the outcomes of crisis team-service user-family encounters are not predetermined. How nurses take up strategies and technologies within the context of different discourses is mediated through their agency and the response of service users and families during the encounter. Therefore crisis teams are mediated by the agency of service users and families also. Actions of crisis intervention are contingent on the interaction of formal structures, such as strategies and technologies and cultural elements, such as the agency of professionals in the crisis team and those who access services. The next section of this chapter is focused on raising critical awareness as to how organisations maintain a status quo and the potential to self-reflect in order to disrupt and resist dominant discourses that prevent people in crisis from engaging in uncertainty and making change.

8.4   Attending to the way one's experiences affect and contribute to the maintenance of a status quo

The outcomes of crisis intervention are necessarily contingent due to the changing relations of power within the process. Agency of nurses within crisis teams is vital to the choices they might make about their context-specific interpretation and uptake of current strategies and technologies. For example, alternative strategies such as recovery-oriented approaches and socially inclusive practice exist in the specific operational context of crisis intervention. Therapeutic risk taking (Freshwater, 2012) from the perspective of socially inclusive policy co-exists in a sometimes, uneasy relationship with the MHA (Stickley & Felton, 2006).

Knowledge and power flow in multiple directions and are not just the possession of those who govern or the processes of government (Tremain, 2012). Undeniably, biomedical, accountability, social development and personal recovery discourses depend on the multiple directions of power for their effectiveness. For example service users who are seen to listen to the expertise of crisis services are viewed as self-activating and self-managing citizens in a discourse of social development, a key step toward the achievement of certain governmental aims. However, even service users who are seen as lacking capacity in biomedical discourse possess the power to contest and resist strategies and technologies of accountability and social development discourses, therefore subvert planned mental health policy outcomes.

Service users and families sometimes resist by refusing to fulfil the roles and tasks expected or do not comply with the technologies required of them in an accountability discourse (Rusner, et al., 2013; Tomes, 2006). Alternatively service users can resist by taking up alternative strategies and technologies to their own advantage to develop action that reflects their needs (Minkowitz, 2010; O'Hagan, 2008). Therefore, strategies and technologies of crisis intervention can encounter resistance from service users and families and their intention can be destabilised and redefined as a consequence. Resistance refers to forms of active or passive, individual or collective agency. Specific forms of active individual resistance were described at times by all of the participants within this study. Rehu, a service user who knew she had a problem with alcohol, subverted the dominant power of doctors in the emergency department and her brother, not by overt acts of disruption but by seeming to accept the subject role of *being depressed* constructed for her by the crisis nurse. However privately she rejected their diagnosis and prescribed medication and developed covert personal strategies for survival and eventual stability.

Active collective agency was also apparent at times as Ruth, a service user described. Ruth had been trying to use the 0800 crisis line to seek support and comfort in times of high distress and found that if she rang she was told she should just take a hot drink or comply with her medications. In her dissatisfaction of being screened out of crisis services, she joined a network of service users for company and later took on a leading role to set up telephone and *drop in* peer support for people experiencing a mental health crisis. In comparison to an active view of agency

involved in the meaning of resistance a passive mode of reply to problematic situations can also take place.

Passive agency occurs when potential users or crisis workers decline to become engaged in dominant strategies and the connected technologies that are intended to produce self-managing citizens. For service users, refusal to be involved in the assessment or treatment on offer was not uncommon. However refusal to engage with the crisis team often has negative consequences for the person in the form of legal sanctions or counter-refusal from services to have involvement in any form (Wand, 2013a). As a type of resistance, even though it might appear as if the service user or crisis worker is doing nothing, passive agency is still a form of agency as it necessitates a particular choice between options or alternative choices (McLeod & Sherwin, 2000; Stoljar, 2011). In the case of refusal, nurses can be complicit in their response but explain the consequences of an assertion to refuse services. For them, legal and policy strategies require that the nurse document technologies in line with a discourse of accountability and the threat of liability is ever present in their practice (Cutcliffe & Stevenson, 2008; Holmes et al., 2012). Nurses working in crisis teams retain the capacity to act in ways that counter the dominant discourses and power of strategies and technologies and at times subvert the intended outcomes of the discourse. The discursive constructions of mental disorder and risk management are developed in part, through the population being subject to a categorisation of binary division (Gagnon et al., 2010) such as engaged/avoidant; responsible/risky; mentally well/mentally disordered. As a result of people in crisis being differentiated from their norm they are subject to different governmental practices.

Biomedical, accountability, social development and personal recovery discourses generate different categories of citizenship for service users such as recovering, risky, self-activated and empowered (Allan, 2012). These categories of citizenship are premised on images of the service user becoming or working toward engagement, self-direction and autonomy from their subject position of mentally disordered and risky. Moreover, the legal and social rights of people in crisis have become discursively constructed as a form of conditional citizenship (Hamer, 2012).

8.5 Self reflection to counter the status quo

According to citizenship theorists, conditional citizenship is based on the idea of a pre-existing entitlement being rescinded as a result of inappropriate conduct (Hamer, 2012; Lister, 2003; Marks, 2001). Within a biomedical discourse, choice or entitlement of choice or consent when mentally disordered is necessarily withheld as a result of risks imposed on the self or others (Hazelton & Clinton, 2001). However, Brannelly (2008) argues that it is an ethical responsibility of services to facilitate citizenship. Moreover, personal recovery discourse does not hold to the existence of universal approaches toward mental distress (Lakeman, 2010). The subjugated discourse of personal recovery provides for uncertainty, where stability in crisis is part of a personal, individual experience or journey.

Whilst the social development discourse has partially taken up personal recovery discourse through strategies such as Blueprint II (MCH, 2012a), in order to *earn* access to services and exercise choice, service users and families are required to adhere to technologies of triage in the biomedical discourse and *guarantee their personal safety* as a product of the accountability discourse. The idea of *earning stability* in crisis results in a reinterpretation of a right to citizenship that is centred on active participation rather than passive entitlement to services (Evans, 2010). This provides a further mechanism for services to classify and codify potential services users and families who present now and in the future. The MHA and other strategies such as the use of DSM to designate allocation of service provision for people in crisis have been subverted from their original purpose of providing services for the *high-risk* population within those who experience mental illness. Instead, the DSM is strategy in which all people who present to crisis services must be objectified with an intention to reduce dependency on services. Thus, for those who attempt to access services early in crisis, as the literature suggest leads to a better outcome (MHC, 2012b), provision of services and rights of people in crisis is reversed through the attempt to exclude them, rather than prioritise them.

Resistance and attempts to destabilise or undermine policy occurs in the everyday practice and negotiations of mental health nurses working in crisis teams. Uncertainty and conflict is produced through the relationship of the nurse and the society in which they work including the complexities of ethnicity, age, gender and

so on (Lloyd, 2007). The identity of the nurse, their agency and emotions are relational and contextual to the identity, agency and emotions of users of services and interconnected social services (McLeod & Sherwin, 2000). Feminist authors argue that in order to act on multiple negotiations the concept of relational agency, rather than reliance on professional or social location alone, is worth considering (Lister, 2003; Theodosius, 2008). Furthermore, relational agency places as much importance on what subjects do not say as on what they do say. Thus, a principle of relational agency is that not speaking about things often means that they matter more.

An unspoken message of social development discourse is that mental health services create dependency and continue to lag behind other public health services through their continued high cost (Kidd & Lampshire, 2010). Moreover, analysis shows that *so called recovery-orientated services* promote an image of empowerment and presuppose an elite user able to articulate and work on personal desires (Juritzen, Engebretsen & Heggen, 2013). The policy focus of crisis services shifted to a more participatory and service user focus from 2000 with an emphasis on community centred principles of modernisation. However, the move from control to choice included tactics of rebranding crisis services as more specialist and limited in their expertise (Sawyer, 2008). Furthermore, rather than a move toward recovery orientated services, the political response has been to generate scientific remedies, which has created an insidious cycle whereby problems are erroneously seen as solutions.

The discursive construction of expertise within crisis intervention has occurred in the interdependency of social development, biomedical, accountability and more recently, personal recovery discourses. The rhetoric of change from control to choice since the publication of the Blueprint in 1998 has culminated most recently in the rolling out of the most current published policy for MHS, Blueprint II (MHC, 2012a). By appealing to the idea of service user inclusion and the public's apparently escalating need for intervention in the beginning stages of distress and across the lifespan, the new policy has certain characteristics that can be seen as promoting choice and new types of expertise (Saario, 2012).

Blueprint II has a strong emphasis on a *service user centred* culture and a sense of an inclusive community is created through the construction of collective

social agencies "all working together in order to produce better outcomes for people accessing services" (MHC, 2012a) to provide new forms of choice and voice. This creates further contestation of the processes involved in the negotiation and translation of what access is and who should facilitate crisis intervention services. Moreover, it highlights the need for nurses to undertake caring that is both satisfactory to service users and political in order to engage in authentic relationships which uphold ethical practice.

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 (Dury & Munro, 2008; Kidd & Lampshire, 2010; Lapsley et al., 2005). Service users and their families want professionals whom they can trust to do what is required. In the next and final section of this discussion chapter, I argue that the tension between normalisation and medicalisation experienced by nurses is a meaningless dichotomy that can be eased by nurses engaging in issues of authentic relationships and what Foucault termed *ethical practice*, in order to balance the scientific, economic and social discourses to which they are subject.

8.6   Building authentic relationships through working on the self in ethical practice

Ethical practice according to Foucault has four dimensions which "inevitably overlap and cannot be dissociated from one another or from the actions that support them" (Allan, 2012, p.284). The first dimension, determination of the ethical substance, involves the classification of the self as the main substance of moral conduct (Foucault, 1988b). Individuals decide which features of the self to work on, or to change. In the social context of crisis intervention a person is seeking help, so it is likely that they will want to convey as clearly as possible the extent of their difficulty and why they might need or deserve help. However service user perspectives, are constructed by others in a way that highlights their need or problem, rather than their capability. Services seek to expose a deficit of those in crisis and mostly fail to take capability into account, as the declaration of deficiency is a pre-requisite to accessing services and the potential of being allocated scarce resources.

Declaration of deficiency is also emphasised in the responsibilities inherent in the roles specified in legislation (MHA, 1992). Whilst the intention of the crisis nurse is to help others, the biomedical discourse surrounding practice involves seeking as much as possible about what is going wrong for the service user so that an assessment and plan can be established (Wand, 2013). Performativity results as the services and their users are not only the objects of various strategies and technologies; they are called upon to take part in the workings of the disciplinary apparatus (Perron, 2013).

The discourse of accountability and social development positions nurses and others as *experts* in the lives of crisis subjects and due to issues of power over scarce resources, it is the nurse, then sometimes later the family, who decide what *work* on the self should occur and what potential for change might take place. In tandem with expertise, biomedical and accountability discourse work together to create a discursive construction of risk management. Consequently, people in crisis who might meet the criteria for authoritative intervention resolve to a power, which transmutes their identity (Perron et al., 2010) and they begin to limit certain aspects of their lives in order to be deemed self-governing citizens, governed by experts in the social development discourse.

In public policy the definition of risk is concerned with the restoration and redress of social inequities and the meeting of citizens needs as a primary function of a welfare state (Dean, 2000). A function of risk management is to determine how and to whom resources should be rationed however; service users have in the most part been excluded from contributing to the development of risk management practices within crisis intervention (Gordon & Ellis, 2013). Dean (1999) states that through governmentality, over time, risk is transformed from inscripted calculations and anticipatory projections of future outlooks and conducts of everyday life, to a process whereby individuals are encouraged to assume lower thresholds of risk acceptance. In other words, to be more accepting of their own actions and to integrate a kind of self-distancing regard for their conduct in the face of uncertain or unwanted outcomes. I argued in the data chapters of this thesis that whilst recovery policy and practices seek to empower people in crisis, clinical recovery is a *catch 22*. Mental health policy has the potential to create freedom to choose, yet subjugates the potential to make changes in times of uncertainty within personal recovery discourse.

This has resulted in a dichotomy in policy of dependency creating crisis services and self-governing citizens.

The second dimension of Foucault's ethical practice is the mode of subjection. Here Foucault was concerned with the ways people recognise how they operate in relation to certain rules and how they find other ways of observing such rules (Allan, 2012). The promotion of compliance, which is sanctioned in legislation and gained in silencing the desires of people in crisis, is brought about by practices that subtly coerce those involved into self-management. Perron et al (2005) point out, the *clinical gaze* transformed from hospital to home in the move from objectifying psychiatric patients, to subjectification of service users through a mental health policy of clinical recovery, underpinned by a discourse of social development. This was highlighted in the analysis discussed in the second data chapter, *all fear and no care.* The subjectification is not in the sense of learned helplessness (Azam Ali & Naylor, 2013; Seligman, 1975), where people with mental illness learn to believe that they cannot control their experience and become passive. Rather, the mode of subjection provides an opportunity to make change in the process of weighing up costs and benefits of participating in self-management differently (Perron, 2013).

Participants in this study highlighted that current crisis services miss the opportunity to construct a different picture of service user uncertainty. Service users clearly articulated that instead of talking about problems, they want to talk about what was happening when the problem was not happening. This is in direct opposition to family, the police and nurses who are problem focused in their approach. Self-practice or ethical work as an aspect of ethical practice, involves what people do not only in order to bring their conduct into compliance with a given rule, but how they might attempt to transform the self into the ethical subject of their behaviour (Foucault, 1988b). For service users this translates to incessant *combat* with their thoughts, feelings and behaviour in the pursuit to escape the label of mental disorder. As I argued in chapter seven *Framing transformative practice,* the challenge that this work poses to people is one of responding to, and for, the *other* without creating further obligations in the *other* (Allan, 2012).

The final dimension of ethical practice is that of *the telos.* This aspect is the perception of an ultimate goal that a person might aim to achieve through ethical

work. Strategies such as clinical recovery policy (MHC, 2001b; MHC, 2012a), suggest crisis resolution is achieved via self-management, despite the presence of symptoms in the experience of distress. However, in the telos, self-mastery is a goal in the journey to transform the self where the person in crisis is expected to undergo positive dissolution, not in the sense of self-absorption, rather, "to become absorbed into the world: a losing-finding of the self" (Allan, 2012, p.284), otherwise, transformation into the self-governing citizen. In the final data chapter, discursive constructs of expertise and uncertainty contribute to a new discursive formation of conditional citizenship (Hamer, 2012), which provides the opportunity to contest what or whom is expert in the lives of those experiencing distress. Whilst Foucault highlights the requirement of ascertaining the rules of acceptable behaviour in relation to others, it is the self as the principle object of care, as a means in which, care for others can occur (Foucault, 1988b).

In his later writing Foucault introduced a conception of ethics, which is a potential frame for the work that people involved in crisis intervention must do in order to understand their responsibilities. The framework of ethics according to Foucault centres on:

> "The forms of relations with the self, on the methods and techniques by which he works them out, on the exercises by which he makes of himself an object to be known, and on the practices that enable him to transform his own mode of being" (Foucault, 1988b p.30).

Foucault did not prescribe exactly what the relationships involved, or give advice as to how people should go about working toward transformation of this kind in practice. Rather he discusses the role of the others involved whom "will tell you the truth" (Foucault, 1988b, p. 30) as they act in the mode of coach, peer, leader, or captain. Foucault's conception of ethics provides an invitation to transgress and reinvent one's self in light of such *truth*. In the transgression toward reinventing one's self, people then have the potential to see themselves as the main source of transformation. To be more precise, people resist being passive subjects merely waiting for others to provide structural or material change in their lives.

In their article concerning citizenship and the government of mental illness, Perron et al (2010) suggest the emergence of a discourse of citizenship "constitutes a break in the history of care to persons who are deemed to suffer from various

psychiatric ailments" (p.101). Citizenship discourse permits for people in crisis to be constituted in new ways, as new objects of that knowledge which require new governing practices and a change in the way crisis teams undertake care of them (Perron, et al, 2010).

Sevenhuijsen (1998) emphasised that to be in need of care is not a negative concept. Some authors argue that the concept of care is mostly absent from mental health policy and has been replaced by the terms such as *response; outcomes; and access* (McLean, 2003; Pilgrim, 2005; Warner, 2009). Barnes (2012) argues that terms such as these, fail to acknowledge the interdependence of people's lives and the risks that are situated in relationships that are unbalanced in terms of power and influence. Power is a key issue between participants, who, in their own way, experienced different degrees of powerlessness.

Crisis services operate within discursive formations where biomedical, accountability and social development discourses converge, continuously reinforcing each other and objectifying the person in crisis in new ways. Self-activating citizens or those acting upon themselves in a self-governing fashion, are expected to participate in all that is on offer and so become the producer, confessor and user of knowledge generated around and about their mentally disordered or *deficit* self (Perron, et al, 2010). Thus, their citizenship becomes conditional (Hamer, 2012).

Determination of ethical substance, with respect to crisis intervention, requires health professionals who research and practice in the field to acknowledge their involvement in the creation of conditional citizenship. Being prepared to critique one's own role and actions in such a way is an opportunity to pay attention to how our practices become engrossed by power/knowledge regimes (Foucault, 1984c). Hook (2011) urges practitioners to critically examine the ways in which they have come to govern themselves and others, through talk and actions concerning the true and untrue. Moreover, 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.

Mental health service users have been instrumental in highlighting the injustice apparent within acute mental health services such as crisis intervention (O'Hagan, 2008; Minkowitz, 2010; Roberts & Wolfson, 2004). Their articulation of

determining ethical substance, or the part of ourselves that is to be worked on, is part of an ongoing resistance to counter the collusion to separate people experiencing distress as a deficit population in need of correction.

In an attempt to align themselves with this dialogue, a movement in mental health nursing to denounce the knowledge/production of service user deficits and disempowering practices has grown (Freshwater & Johns, 2005; Happell, 2005; Holmes, Rudge & Perron, 2012). However, authors note that the apparently *new* discourse of listening to service users, causes widespread tension for a majority of health professionals, as they privately remain pessimistic yet publically feel obliged to join in on the public rhetoric of recovery and social inclusion (Pilgrim & Tomasini, 2012; Wand 2013). This calls into question the knowledge-production of nursing practice including undergraduate nursing preparation and the process of knowledge development available for nursing working in the scope of mental health nursing.

Currently the education of future nurses is structured on facilitating the micro-level nurse-patient relationship. The education of student nurses is an incremental building of competence to develop confidence in undertaking a therapeutic contract with service users and families in order to assess, plan, implement and evaluate the problems of those in potential receipt of their care (NCNZ, 2012; NZCMHN, 2012). Published studies however, continue to highlight that student nurses are unlikely to choose a career in mental health (Happell & Gough, 2007; Nadler-Moodie & Loucks, 2011); and indicate that not only has nursing education failed to address this, but: "it has indeed assisted, through the process of professional socialisation, in exacerbating it" (Stevens, Brown & Graham, 2013, p. 213).

Given the social impact of mental health and the politics of service access and care delivery, political consciousness and action from nursing is rightly called upon in order to engage in authentic relationships that involve both caring and political action (Perron et al., 2011). Furthermore, nurses are not a group that need to be controlled and governed by dominant discourses, instead they are relational people ethically obliged to care for the self before they can care for anyone else (Perron, 2013).

Throughout this thesis I have suggested that mental health nurses are erroneously positioned as having to choose either caring for people in crisis or engaging with the politics of service access and delivery. Indeed, I am arguing that by engaging with one this binds nurses to the other and vice versa. Nurses working in crisis teams are involved in a bigger picture of health and social service care delivery. Therefore the ethical merit of nursing care requires nurses to be positioned as a leader in the formation of authentic relationships with people who access services, or those who access services on behalf of others. In doing so, Foucault's ethical practices of self-formation can balance the scientific, economic and social strategies and technologies that continually constitute subjects in this era of modernity.

8.7   Reflections on the study and concluding comments

Much changed within my own life as I worked on this topic and listened to and read the words of participants; I have come to a different understanding of the topic. As I commenced the project I purposefully engaged actively with the participants and sought their input to determine how services could be developed and improved and in doing so our shared concerns enabled uncertainty to be voiced. Following the data collection, my two daughters and I experienced the significant loss of my husband and their father and in the midst of that uncertainty I gained personal understanding of how broken one can feel in an experience of crisis. Lakeman et al., (2013) writing on engaging service users and families as participants of emancipatory research resonates with my own experience of having the time and opportunity to work through how feelings, thoughts and actions can be understood and valued in times of personal and relational change. The generous participation from service users, family members and colleagues from nursing and the police to be involved in this project has been about building engaged communities.

Without hesitation I would argue that there is much opportunity for mental health nurses who work alongside people in crisis to reconsider how the origin and agenda of their discipline needs to be grounded in critical awareness. Emancipatory mental health nursing that is grounded in critical awareness can create space and freedom to think independently. Furthermore, critical awareness can lead to recognition that the practices of crisis intervention are made possible and shaped by

the range of strategies and technologies that justify the discourses, but more than this determines practices. More exactly, crisis intervention is the result of an engagement between those involved, their knowledge of, and skills in using, the various formal interventions and understanding of policy outcomes; alongside their context specific moral and emotionally charged experience of necessary uncertainty.

Clearly there are unlimited opportunities to collaborate with service users and families to further research in this field. The interconnected variables of social, economic, scientific and educational discourses provide much opportunity to further engage in critical awareness and action to improve the access and delivery of mental health crisis services in the future. In particular, the undergraduate education of nurses and opportunities for post-registration education are key to raising critical awareness and will be instrumental in disrupting structural and systemic inequities within mental health care delivery alongside framing and anticipating transformative action within the nursing profession.

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