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Managing the Unpredictable – Discourses of Power and Knowledge in Mental Health Risk Management

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ABSTRACT

In mental health, the *safety and risk concept* refers to a complex phenomenon with strong connections to risk management strategies, simultaneously influenced by the ideals of patient involvement and empowerment. The aim of this paper is to analyze discourses linked to patient involvement and the management of risk and safety, as articulated in the protocol for the Early Recognition Method (ERM) risk management strategy. As an analytical tool, we have drawn inspiration from the discourse theory of Michel Foucault and utilized Hall's six elements for discourse analysis. Our analysis indicates that the ERM protocol rests its discursive authority upon two main discourses: one, a scientific medical discourse and the other, a discourse strongly linked to empowerment and patient involvement. These two discourses are interrelated in a complex fluctuation of power dynamics in which they sometimes complement each other and, at other times, are in conflict. We claim that by applying a Foucauldian angle on discourse, power, and knowledge, our analysis may facilitate a critical awareness of the power dynamics inherent in risk management discourses and provide valuable insights into how articulations of safety and risk – combined with ideals of participation and empowerment – contribute to reframing practices in mental health care.

1 | Introduction

1.1 | Background

In mental health care, the *safety and risk concept* is becoming an increasingly important topic (Flintoff et al. 2018; Slemon et al. 2017; Smith-Merry 2018). The safety part of the concept implies creating a safe environment for patients to stay in and for staff to work in. The risk part addresses how to manage patient behaviors that represent a risk for patients and staff (e.g., aggression, violence). At the same time, there is an emphasis to avoid coercive measures and instead strive to involve patients in interactive risk management strategies (Gildberg et al. 2021; Renwick et al. 2016; Whiting et al. 2021).

The safety and risk concept refers to a complex phenomenon that covers multiple different terms and angles from which to address them. For example, patients' risk behaviors are captured by the angle of "workplace violence," referring to inpatient aggression towards staff, or "violence-risk" behaviors, referring to patients' having committed severe offenses in society. Numerous strategies have been developed to assist mental health staff to better manage patients' aggressive behavior (Björkdahl et al. 2023; Duxbury et al. 2019; Gooding et al. 2020; López-Ros et al. 2023). Additionally, there is increasing attention to involving patients in risk management strategies, referred to in various terms such as patient involvement, the consumer perspective, consumer representatives, service user, and Shared Decision Making process (Eidhammer et al. 2014; McPhee et al. 2023; Ray and Simpson 2019; Tambuyzer and Van Audenhove 2015).

The safety and risk challenges are rooted in the history of mental health and psychiatry. When psychiatric institutions were established in the 19th century, the attitude toward patients and how they should be treated was paternalistic (Szmukler 2014). Psychiatrists were the experts, and there was little room for patients' own opinions about their needs. Since then, attention to patient rights such as empowerment, autonomy, person centeredness, shared decision making, consumer perspective, and patient involvement and participation have grown. All of these are strongly connected to the same overarching concept of respecting basic human rights and individual autonomy (Ahlstrand et al. 2024; Beyene et al. 2019). Changes in legislation and guidelines reflect how this shift in focus has taken place (Council of the European Union 2019). This quotation from the Norwegian National Guidelines for Assessment, Treatment and Follow-up of persons with Psychotic Disorders serves as an example of how authorities have embedded the ideal of patient involvement and patient responsibility:

> *All good mental health care puts the patients/users and their close relations in focus to enable the patients/users to take responsibility for themselves and their own development. One must therefore facilitate the patients/users having a large influence on their own treatment and follow-up, and that their close relations get the help and support they need. Participation has its own value as a therapeutic agent, as it may provide increased autonomy and contribute to making the patients/users experience hope and more control over their own lives.*
>
> (Helsedirektoratet The Norwegian Directorate of Health 2013, 22)

This statement acknowledges patient involvement as a vital factor in mental health care. It represents a higher emphasis on human rights in general, but also justifies patient involvement on the basis of better treatment and patient outcomes (McPhee et al. 2023). Moreover, Binnema (2004) explains how mental illness, in itself, causes a lack of feeling in control and how a hospital environment may contribute further to a feeling of losing control over one's own life. He suggests that empowerment is a core variable for achieving better mental health. In a similar way, the *recovery-oriented perspective* developed from the late 1980s highlights how individuals with mental illnesses can facilitate their own recovery processes, often supported by mental health professionals (Deegan 1988; Slade 2009). A recovery perspective involves shifting the focus from psychiatric illness to individual healing processes. Recovery is often categorized into clinical, personal, and social dimension (Nielsen et al. 2023; Sommer et al. 2021).

There is growing concern about the impact of media coverage on violence perpetrated by individuals with mental disorders. As Perron et al. (2010) point out, this portrayal is often far from reality, and although media frequently link violent acts and mental illness, research has shown that mentally ill persons are more likely to be the victims of violence than the perpetrators. This fact needs to be balanced with the fact that in some cases persons with mental illnesses do pose a threat and a risk to their environment (Elbogen et al. 2016; Whiting et al. 2021), and this risk will often serve as a criterion for the use of treatment practices such as seclusion, restraints, or involuntary medication (Gooding et al. 2020).

In forensic mental health services, many strategies are used to address and manage violence and aggression. One course of action is the use of risk management strategies to help identify risk situations and take measures to minimize the risk of aggression or violence (Almvik et al. 2000; Douglas et al. 2014; Maguire et al. 2018). Empowerment and user involvement as an ideal to strive for in mental health care has also found its way into risk management strategies. For example, Ray and Simpson (2019) explained the call for patient involvement in risk formulation and published a literature review on shared decision making. It included those strategies which both serve the concepts of risk formulation and include patient involvement in the strategy. One of the five risk management strategies that meet Ray and Simpson's criteria is the Early Recognition Method (ERM). ERM is a risk management strategy urgently aiming, together with the patient, to identify, formulate, and monitor patient-personalized early warning signs of aggression (Fluttert et al. 2010; Fluttert et al. 2008).

In this article, we reflect on the complexity of the safety and risk concept with inspiration from the discourse theory of the French philosopher Michel Foucault. His perspectives on power can provide healthcare providers a tool for critically analyzing the manner in which they perform their services. Foucault's perspective on discourse, power, and knowledge may provide valuable insights into how articulations of safety and risk – combined with ideals of participation and empowerment – contribute to reframing practices in mental health care.

1.2 | Aim

This paper aims to analyze discourses linked to patient involvement and the management of risk and safety, as articulated in the ERM risk management strategy, to facilitate a critical awareness of the power dynamics inherent in risk management discourses.

2 | Theoretical Background

The concept of discourse has its origins in linguistics and semiotics (Howarth 2000). Discourse analysis as method has been developed by various contributors in the social sciences, but it is predominantly associated with the works of Michel Foucault (Foucault 1971). His approach is based on the idea that reality is socially constructed and emphasizes the significance of examining how language is shaping our perception of reality (Jørgensen and Phillips 2002). For our analysis in this article, we rely on Hall's (2001) approach which is based on Foucault's descriptions of the possibilities of discourse analysis.

2.1 | Foucauldian Discourse Analysis

Over several years, Michel Foucault developed his theories of discourse and discourse analysis as key components of his

academic work. He explained how power is both transmitted and produced within discourses, while also being undermined and exposed by them. Discourses are viewed as unstable and complex, not completely submissive to power nor mobilized against it (Foucault 1990). In each society, the quest for scientific knowledge, establish "regimes of truth" which allow researchers to differentiate between true and false statements (Foucault et al. 2002). Analyzing discourses reveals the forces that promote or inhibit the elements that make up the discourses and the production of truth.

Foucault explained the procedures that organize and control the production of discourses. He claimed that

> *...in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality.*
>
> (Foucault 1971, 8)

Foucault's concepts and theories are multifaceted and intricate. We choose to highlight his ideas concerning power and knowledge, the concept of governmentality, and the role of technologies of self in power relations.

2.1.1 | Discourse, Power, and Knowledge

One of Foucault's fundamental assumptions is that discourse is strongly connected to knowledge and power: "It is in discourse that power and knowledge are joined together" (Foucault 1990, 100).

Traditionally, power is viewed as a force flowing in one, downward direction, from the powerful, the possessors of the power, to the ones upon which the power is exerted. Foucault challenges these assumptions and asserts that one needs to study power where it has its effects, in the capillary level. This is where power is manifested and enacted and represents its ground level. Power is present in all human relations as a complex phenomenon, flowing in multiple directions, always changing (Dreyfus and Rabinow 1982; Foucault 1990; Foucault et al. 2002).

Foucault also studied extensively the concept of knowledge and argued that knowledge is socially constructed through discourse. He encouraged us to question our taken-for-granted assumptions by generating unease and discomfort in areas where our ideas had become too familiar and comfortable, based on widely accepted truths (Gordon et al. 1991). He emphasized the importance of critical thinking: "To do criticism is to make harder those acts which are now too easy" (Foucault et al. 2002, 456).

Knowledge makes it possible to exercise power, and this process simultaneously works in the other direction: When power is exercised, it also creates knowledge. Established truths has power over the way we conduct our behavior and also on how we try to regulate the behavior of other people (Dean 2010; Hall 2001). For something to become a (scientific) truth, it is dependent on accepting and relating to certain power mechanisms and aspects. This dynamic process between power and knowledge has a strong connection to the reproduction and adjustment of discourses (Hall 2001).

2.1.2 | Governmentality

The *governmentality* concept serves multiple purposes in Foucault's explorations of power in modern societies. He traced a transformation of the wielding of power through history. In earlier eras, the use of power was depicted as a primitive, brutal, coercive, and oppressing force which was manifest and highly visible. Leading up to modernity, power represents a less visible and more elusive force. Governmentality was introduced by Foucault and enables his explorations of power in modern societies. The focus is not on the governing of wealth and territories but the control of populations and individual conduct – in line with the concept of bio-power (Gordon et al. 1991). Governmentality involves a mode of power directing its force towards life itself, the living man, the governance of thoughts and actions, i.e., governing through the "conduct of conducts" (Foucault et al. 2002, 341). The conduct of conduct represents the essence of governmentality: making citizens regulate and control their own behavior (Dean 2010; Gordon et al. 1991).

In the era of governmentality and bio-power, individuals are subjected to and expected to employ power techniques like normalization, examination, and self-surveillance in institutions as schools, churches, mental health institutions, and prisons. Support, encouragement, and praise are the key characteristics of governmentality as opposed to earlier forms of power relations which were based on sanctions and force (Foucault et al. 2002; Foucault and Gordon 1980). The former is seen in different modes of conversational and dialogue-based techniques such as motivational interviewing, counseling, self-help groups, and management development which invite clients to share their thoughts, motives, and hopes (Born and Jensen 2010; Karlsen and Villadsen 2008). These techniques shape and structure conversations and dialogues. The silent and attentive therapist or coach creates a space for the clients to talk, share their inner thoughts, and elaborate on their difficulties and shortcomings. Consequently, the client is expected to assume responsibility for their situation and commit to pursuing their self-defined goals. In this way, these technologies govern the conduct of the client, and the subject is governed to be self-governing (Karlsen and Villadsen 2008; Rose et al. 2006).

The final objective of governmentality is to provide security for the population. However, Foucault argued that danger and risk are always present as opposites of security. Things can always go wrong, but within that uncertainty, there also lies a possibility of doing something to reduce the risk (Gordon et al. 1991).

2.1.3 | Technologies of the Self

As part of the practices of governmentality, Foucault introduces new technologies of government. *Technology* refers to the machinery of society, practices that are aimed at controlling and regulating the population (Eliassen 2016; Foucault and

Gordon 1980; Foucault and Rabinow 1997). *Technologies of the self* are described as the practices individuals use to govern themselves; the conduct of conduct (Dean 2010). The technologies of the self involve an element of comparison to others, to what is considered as normal and are related to the individual's cultural context (Eliassen 2016; Rose et al. 2006). These technologies imply the creation of knowledge about oneself, an obligation for all individuals living in the age of governmentality. One should know oneself, explore oneself, and tell the truth about oneself (Foucault 1980). By implying self-control and regulation, the technologies of the self might reduce a subject's freedom. Yet, subjects become independent of external policing when they adopt these standards internally. This opens the way for a higher degree of autonomy and freedom. Individual subjects have the freedom to take part in creating their own truths about themselves and the autonomy to choose the content of the regulations and controlling practices (Rose et al. 2006).

3 | Methodology

3.1 | Data Material

This article is based on an analysis of the Norwegian version of the ERM protocol (Fluttert, Eidhammer, et al. 2013). The ERM concept is rooted in Birchwood (1992) original concept of identifying early signs of psychoses in patients with schizophrenia in the United Kingdom. Van Meijel et al. (2003) adapted and expanded Birchwood's concept in a Dutch context, creating the Dutch "Early Signs and Early Intervention Protocol" in patients with schizophrenia. Fluttert built on van Meijel's protocol by incorporating the idea of early warning signs of aggression, expanding the target population to include all mental health patients dealing with aggression and violence (Fluttert, Van Meijel, et al. 2013; Fluttert et al. 2011). The core concepts of early recognition and self-management, as well as signature risk, remained consistent from Birchwood to Fluttert's protocol, which became known as the ERM protocol. The Dutch ERM protocol led to its translation and implementation in Germany, Belgium, Sweden, and Norway. The expansion of the ERM protocol to other languages and countries provides an opportunity to analyze it through the lens of Foucauldian theories, enabling a deeper understanding and interpretation of the discourse surrounding ERM. Given that the first and third author of this article live in Norway, with Norwegian as their first language, it was the most natural choice to analyze the Norwegian ERM protocol. The translations of quotations from the protocol provided in the Findings section are done by authors Bakke and Juritzen.

The protocol is a small booklet printed in A5 format. The title is *ERM – Early Recognition Method: "From Black box to Brain box" – Risk management in Psychiatric Health Care*, and it consists of 22 pages describing all the steps of the ERM strategy and an appendix containing the ERM plan template. The protocol states that it is "intended for staff trained in working with Early Recognition Method (ERM) who have acquired knowledge about ERM" (Fluttert, Eidhammer, et al. 2013). Mostly, the booklet contains text, but there are also some illustrations, including a few flow sheets and textboxes.

3.2 | Methodological Toolbox/Analysis

This study uses the theories of Foucault as a methodological tool for analyzing discourse. Although Foucault never outlined a specific methodology or even developed a specified recipe for conducting discourse analysis, his works and those of other scholars who have built on his theories provide a substantial contribution to the literature on discourse analysis. Foucault once described his books as a toolbox where readers could find useful tools for their purpose (Lotringer et al. 1996). In this article, we have chosen to base our analysis on Hall's (2001) six essential elements for analyzing discourses: *statements, rules, subjects, authority of knowledge, practices*, and the *arising of new epistemes*.

The first element, *statements*, focuses on what knowledge statements offer regarding the phenomenon in question. What is actually being said, and how do these statements contribute to creating knowledge? The second element, *rules*, focuses on the rules that apply within the discourse, and what can or cannot be said. In what certain ways is it possible to talk about the phenomenon? The third element, *subjects*, concerns the attributes of the individual personifying the discourse. What characteristics are the subjects expected to have, according to the knowledge that the discourse creates? The fourth element, *authority of knowledge*, analyzes how the discourse acquires authority. In what way does the discourse establish and embody the truth about the matter? The fifth element, *practices*, looks at which practices are legitimized by the discourse. How and whose conduct is being governed through the discourse? Finally, Hall's (2001) sixth element highlights the importance of acknowledging the constant emergence of new and different discourses or *epistemes* which are larger and more profound patterns of discourses. Discourses are temporary and floating and are constantly changing as history moves forward, and this has to be addressed when analyzing them.

4 | Findings

In our analysis, we draw on the elements Hall (2001) outlines. They are helpful in breaking into parts what a discourse can be made of, and they serve as a way of making the discourses visible. When describing our findings, we use the elements as terms when explaining what our analysis has revealed. The terms are written in bold font to show how and where we have applied them for analytic purposes.

Our analysis indicates that the ERM protocol rests its discursive authority upon two main discourses. One of these is represented by the protocol applying a scientific language related to the medical and psychiatric tradition, and the other one is a discourse strongly linked to the ideal of empowerment, citizen rights, and patient involvement.

4.1 | The Medical Science Discourse

In the known history of humankind, there have always been persons with ways of thinking and acting that differ substantially from the general population. However, to categorize

certain behavioral traits as illnesses of the mind is a quite recent invention, given the history of medicine. It was not until the Enlightenment that we, meaning so-called Western countries, started to refer to this phenomenon as an illness (Foucault 2006). This shift also led to a change in practices, legitimizing the treatment of mental disorders, just as the case was for any physical disease, and paving the way for a specific medical discipline called psychiatry. Thus, what we might call a psychiatric discourse paved the way for the practice of psychiatric treatment (Perron et al. 2010). In the early years, the psychiatrist had authority to determine treatment methods based on his clinical discretion (Szmukler 2014). However, this is no longer enough. Now there is also a demand for evidence-based treatment methods, preferably methods that have been tested through scientific studies carried out according to natural scientific ideals.

Hall (2001) claims that discourses create **rules** about how it is possible to talk about a certain topic and also set boundaries about other ways to talk about it: The discourse "**rules** out" certain ways of talking. Our analysis shows that the ERM protocol embeds a discourse of categorizing specific behavioral traits as a mental disorder. Aggression, along with a number of other behaviors, is described as a symptom of mental illness. By using this discourse, the ERM protocol legitimizes its own existence as a risk management strategy facilitating treatment of symptoms of mental illness. The **rules** of the discourse are thus strongly connected to the conduct – or practices - of the subjects. The discourse is revealed through words and phrases such as *patient, symptoms, treatment, taking his medicine*, and *having a relapse*. This kind of discourse builds strongly upon the technology of normalization, the categorization of some behaviors as normal and others as deviant.

The following quotations from the ERM protocol illustrate how the discourse encourages Hall's element **practices** when nursing staff are urged to initiate dialogues to explore a patient's speech, but also rejecting his speech when it is not considered useful:

> *Does the patient feel he has a mental illness that has any bearing on for example the occurrence of risk behavior or decreased function? (...)*
> *If it is difficult or impossible to discuss the patient's view on his own illness, the subject is laid to rest.*
>
> (Fluttert, Eidhammer, et al. 2013, 10)

In the scientific medical discourse, the mentally ill patient is created as a deviant **subject**; he is different from what is considered normal and needs medical treatment. The staff, on the other hand, represents normality, the voice of reason. A feature of the intervention plan in the ERM protocol illustrates this division between patients and staff. The interventions are divided into three groups of acting **subjects**: the patient, the staff, and the patient's family/network. The **practices** that the discourse encourages the subjects to perform are listed as possible actions to be taken should the patient display early signs of relapse. However, whereas for the patient and the family/network there are categories of actions both to perform and to avoid, the staff only have the option of actions to be performed, while the category of actions to avoid is omitted for them. This is an example on how the discourse constitutes **rules** about how it is possible to talk about the patient and the staff, thus creating their different **subject** positions, which then legitimizes different kinds of **practices** for the subjects.

We also notice how this discourse positions the patient as a passive **subject** and the healthcare worker as the active **subject**. Certain **statements** portray the patient as reliant on the staff to provide the necessary treatment: "The patient's limitations make him dependent on others in recognizing early signs and intervening on his behalf" (Fluttert, Eidhammer, et al. 2013, 12). This aligns with the conventional, paternalistic relationship between healthcare staff and patients.

Also worth mentioning is how the **authority** of the knowledge about the patient is based on scientific research, which, in turn, is based on statistics. The characteristics of the individual patient is less acknowledged, and he is given a **subject** position as a member of a larger group who share the same attributes: "The table shows examples of conditions and forms of expression in patients with psychotic disorders and personality disorders" (Fluttert, Eidhammer, et al. 2013, 8).

By using statistical data as a basis for creating knowledge, the ERM protocol embodies a discourse that aligns with the ideal of natural sciences. It advocates the **statement** that science is the producer of true knowledge. This is also seen when the protocol "talks" in scientific language, using words and phrases such as *preventing, by means of, preliminary findings, relevant, occurrence, observation*, and *investigate*. By invoking these kinds of **statements** and words, the protocol, focusing on the fact that the ERM has been developed and tested in a scientific manner, claims its discursive authority, as illustrated in the following from the introduction to the protocol:

> *The research on ERM is described in Fluttert's Ph.D. and has generated multiple international publications. The first intervention study on ERM was conducted at the FPC Dr. S Van Mesdag in the Netherlands showing that the use of seclusion as a coercive measure and the level of aggression were significantly reduced after implementing ERM.*
>
> (Fluttert, Eidhammer, et al. 2013, 1)

Another aspect of the quotation above is how it argues that it is possible by means of scientific research to address the issue of risk management. The ERM protocol seems to want to inform us that violence can be avoided, or at least reduced, if we use this science-based treatment method. To reduce the risk of violence, an essential part of the method is the **practice** of monitoring early signs of aggression. As stated in the protocol: "Examine and document the occurrence or absence of early warning signs" and "Write down the early warning signs recognized by the nursing staff based on observations made" (Fluttert, Eidhammer, et al. 2013, 13, 17).

These findings show how the ERM protocol relates to solid and traditional forms of science and ways of producing scientific knowledge, within a biomedical understanding of mental

disorders, their medical treatment, and management of aggression. A type of professional authority is established which gains its legitimacy through expert knowledge. The patient needs a highly qualified expert if his aggressive behavior is to be controlled.

4.2 | The Empowerment Discourse

Western societies pursue the ideal of empowerment and citizen involvement. This affects multiple fields, such as law, education, social work, and health services (Perron et al. 2010). Mental health care (psychiatry) is no exception, and the ERM protocol builds extensively on this ideal. The following quotation is an example of how the protocol advocates the ideals of patient involvement: "It is essential that the patient himself is able to identify his early warning signs and to initiate stabilizing actions. Thus, user participation and collaboration between the personnel and the patient (and possibly his family/network) become of great significance" (Fluttert, Eidhammer, et al. 2013, 1). We can see here how the main message of the quotation is that the success of the ERM method relies heavily on patient involvement, which paves the ground for a more active patient **subject**.

This active patient **subject** is also constituted through the **practices** that the protocol articulates: "Describe interventions together with the patient, which he can initiate himself, to obtain stability and avoid risk behavior" (Fluttert, Eidhammer, et al. 2013, 18). In this subject position, the patient collaborates with the staff and participates in his own treatment, the process of managing his risk of being aggressive. This contrasts with medical scientific discourse, where the patient was constituted as the passive receiver of treatment.

The protocol contributes further to the discourse of patient involvement by **statements,** arguing that the patient is the one with the best and most valid knowledge of himself, as shown in these examples:

> *It is preferred that the primary source of information about the early warning signs is the patient himself (...) An important point is what the patient himself thinks about his own behavior and condition (...) The starting point [for successful application of ERM] is the patient's experiences.*
>
> (Fluttert, Eidhammer, et al. 2013, 6, 14, 15)

In these quotations, the patient is the primary source of knowledge about himself. This also constitutes a knowledge of a different kind compared to the knowledge building on the scientific medical discourse, which is established through statistical and quantitative methods. This other knowledge is unique, contextualized, and subjective and is inaccessible unless the patient shares his thoughts in the dialogue with the staff. The patient is thus constituted as a unique and valuable **subject**. The use of genitive shows that he is considered to be the owner of the knowledge and the phrase "the patient himself" is used multiple times, thus underlining who is in focus. By drawing on how Hall sees the **subject** as a product of discourse and the bearer of knowledge, this would suggest that the patient is given the **subject** position of an individual possessing exclusive knowledge and thus also the power to share or not share his valuable knowledge with others. He is also expected to submit to governmentality-based **practices** by making use of technologies of self. He must take part in self-examination, self-surveillance, and confessional **practices**. He should "*avoid stress and learn coping skills," "develop acceptable behaviors,"* and, together with the staff, he should *"describe actions which he can initiate himself, to obtain stability and avoid risk behavior"* (Fluttert, Eidhammer, et al. 2013).

What our analysis reveals through these quotations is how the patient as an active s**ubject** is expected to do the talking. He is given the opportunity to define, explain, and describe his views and experiences. The staff are given the position of more silent, listening **subjects**, as the one described by Karlsen and Villadsen (2008). They are expected to perform the **practice** of being silent and waiting patiently, thus creating space for the patient to talk and share his valuable knowledge.

When we have examined this second discourse of the ERM protocol – the empowerment discourse – we find a discourse that clearly nuances who is given authority and power. The patient becomes indispensable and invaluable if the plan is to support the staff's (the experts) succeeding in their efforts to activate a speaking, participating patient. Is this "will to empower" (Cruikshank 2019) sufficient to achieve the goal?

5 | Discussion

The aim of this study was to analyze discourses linked to patient involvement and the management of risk and safety, as articulated in the ERM risk management strategy, to facilitate a critical awareness of the power dynamics inherent in risk management discourses.

By utilizing a Foucauldian approach and building on Hall's perspectives on Foucauldian discourse analysis, we have analyzed the protocol for the ERM strategy. Based on the findings, we discern that the ERM protocol has built its discursive authority on two fundamental discourses: medical science and empowerment. We will discuss how these discourses contribute in constituting power relations which may affect practices in mental health care.

5.1 | The Medical Scientific Discourse – Consolidating Expert Power and Knowledge

Our analysis reveals that the division between normal and deviant is present and taken for granted in the medical scientific discourse. The ERM protocol is not questioning the taken-for-granted truth that the patient suffers from an illness of the mind and that this makes him different from what is considered normal. This kind of discourse, constituting mental deviances as an illness, is deeply rooted in our society and has become a widely accepted truth (Foucault 1967).

Foucault also describes the rule he calls *the division between reason and folly* and how "whatever a madman said, it was taken for mere noise" (Foucault 1971, 9). In other words, the

discourse determines which statements are considered valid and truthful based on whether the speaker is considered mentally ill or not. Foucault claims that although in modern times, we do not simply reject his speech, we still do not consider it to be the truth. Instead, we listen to it to decipher it, to find another hidden meaning behind it, or to use it as a proof of mental illness. This indicates that the discourse of mental illnesses has its effect on the capillary level by determining how staff interprets a patient's statements. This discourse's division between normality and deviance legitimizes disregarding a patient's actions or statements, categorizing them as symptoms of illness rather than acknowledging them as a patient's genuine wishes and needs. Furthermore, this discourse also takes for granted that the staff represent "the voice of reason" (Foucault 1967, 1971). A specific example of this is how the ERM plan clearly instructs patients and their network on what to avoid when managing the early warning signs, but there are no corresponding instructions directed toward healthcare staff. Does this suggest that only non-professionals can make misjudgments and therefore need guidance? This kind of "us and them dichotomy" create subject positions in which the mentally ill subject is "*presented as essentially incapable of performing responsibly, self-reliably and effectively as a citizen*" (Oute et al. 2015, 281). The "us and them dichotomy" draws a picture of a power asymmetry more in line with the traditional paternalistic orientation of the patient-health professional relationship. This position presents challenges and may appear contradictory to the ideals advocated in the empowerment discourse of the protocol.

In our analysis, we find that power and credibility are established by relating the ERM strategy's contents and its effect to existing solid research along with further research on various aspects of the ERM strategy. We can also see that when a plan addresses those it is made for – healthcare staff and their patients – it is based on power relations which might be described as traditional and paternalistic, with the practitioners of the scientific strategy being the experts in relation to their patients.

5.2 | The Empowerment Discourse – Consolidating Patient Power and Knowledge

The ERM protocol also refers to signature risk and the importance of finding the individual warning signs and, acknowledging the uniqueness of the individual patient. This orientation is shifting the weight from the objective, observing, and diagnosing gaze of the health professionals to the perspective of the patient. The patient's knowledge of himself is highly valued and becomes central in the work of managing the risk of aggression. This discourse constitutes a participating patient who actively uses his knowledge of himself to reduce the risk of new episodes of aggression. This shift in focus represents a more empowering approach to the patient and is in line with a general focus on patient rights participation and person centeredness (Council of the European Union 2019; Cruikshank 2019; Karlsen and Villadsen 2008)

In the ERM protocol, the patient is established as an active subject who is expected to take charge, by describing his warning signs, defining interventions, and initiating actions – in cooperation with his network and healthcare staff. The act of sharing his warning signs also comes with an obligation and an expectation to act on these signs and to better himself and to employ the various technologies of the self (Foucault 1980; Foucault and Rabinow 1997). These active practices are conducted by someone with insight, someone who is included in the risk management – managing the risk of violence. The same kind of language can be seen in government documents, such as the one quoted in the introduction, i.e., words like participation, influence, autonomy (Helsedirektoratet [The Norwegian Directorate of Health] 2013). It is a potential risk that healthcare staff are expecting too much when they anticipate seriously ill people taking that much responsibility (Perron et al. 2010), thus paving the ground for continued passivating of those patients who are not able to participate and claim their own empowerment (Dahlborg Lyckhage et al. 2017).

Patients' active participation in their own treatment aligns with contemporary ideals of participation, shared decision making, and empowerment. Through a Foucauldian lens, these practices reveal aspects of governmentality. Rather than having external control, domination, and coercion imposed, the patient actively enacts these power mechanisms by internalizing these forces enabling him to exercise self-governance. The ERM plan creates a context where the patient's behavior is governed by conduct of conducts. Patients have openly discussed their challenges in managing aggression and their specific, subjective warning signs, and they are committed and obliged to handling this risk situation (Foucault et al. 2002). Patient involvement can be understood as dependent on a patient's complying with recommendations of professionals and acting accordingly, making choices which are considered "right" by healthcare staff (Boman et al. 2021; Oute et al. 2018; Powers 2003). We ask if this could be the case with the ERM protocol as well? Is the patient only allowed to participate and be empowered when his utterings are considered to be the "right" ones, the "normal" and not the "deviant"?

Using the lens of Foucault's governmentality perspective, we argue that the ERM protocol, by leaning on the empowerment discourse, is constructing a discourse that includes practices based on technologies of the self (Foucault and Rabinow 1997). The problem of power is not "solved" by shifting the weight from the more traditional and paternalistic medical view. Contrary, the power dynamics have shifted from visible and paternalistic power relations to power relations that make the individual capable of "self-governing," thus consolidating the knowledge of the patient.

5.3 | The Two Discourses – Conflicting or Complementing?

We have clarified how the ERM protocol is founded on two main discourses and how they are constituted through elements of power and knowledge. We will next discuss how these discourses relate to each other and how we can comprehend the fluctuation of power dynamics between them.

Our analysis has shown how the discourses constitute two distinct patient subjects. The first is the passive patient,

primarily a recipient of treatment very much in accordance with a traditional paternalistic medical discourse. In this discourse, the patient subjects are receivers of treatment from experts, rather than active contributors in the shaping their own treatment (Pelto-Piri et al. 2013; Szmukler 2014). The second patient subject emerges when the ERM protocol bases its discursive authority on the discourse of empowerment. This patient subject is an active participant, encouraged to take control by engaging in their own treatment. An active patient subject aligns with modern ideals within health care services and is viewed as a positive and advantageous position for the patient. However, the privilege of being an active participant also carries an implicit expectation of the patients assuming responsibility (Boman et al. 2021). This aspect underscores the ambiguity of patient involvement.

Dahlborg Lyckhage et al. (2017) show similar discursive conflicts when the patient subject is constructed both as an active subject with unique knowledge and, simultaneously, as a more traditional recipient of information and treatment provided by expert staff. They question whether it is only the most resourceful patients who can speak up for themselves and benefit from greater influence and responsibility while the more vulnerable patients are still in danger of being subjected to traditional medical paternalism.

We observe how the discourses of the ERM protocol are interconnected, bridging both a traditional medical expert perspective and one that necessitates and values the patient's self-expert view, two seemingly contradictory discourses. The first is traditionally paternalistic; the second is participatory. In addition, Foucault's perspective allows for the examination of ambiguities and contradictions within the democratizing, dialogic, and participatory practices. This is a shift away from external control and governance, as known from paternalistic expert authority, toward the patient's responsibility for self-control and actively safeguarding their own health and autonomy (Dean 2010; Martin and Waring 2018; Reid and Alford 2023; Rose et al. 2006). The power dynamics are shifting from external control and domination to the governmentality type of conduct of conduct (Foucault et al. 2002).

The scientific medical discourse constitutes a knowledge and a truth about mental disorders as illnesses in need of treatment. However, over the past few decades, groups of both patients and mental health professionals have argued that there are other ways of viewing these patients' thoughts and behaviors and question the practice of diagnosing and treating them as strictly medical illnesses. The emergence of these critical voices provides a competing perspective in relation to the dominant medical discourse. It demonstrates how alternative perspectives challenge the established “truths” and the knowledge/power expressed through mainstream scientific discourse in the psychiatric field (Davidson 2016; Nielsen et al. 2023; Slade 2009).

Both the medical scientific discourse and the empowerment discourse speak in favor of using information about early warning signs as a means of minimizing risk. The goal is to manage and handle risk of aggression and violence. When the early signs preceding episodes of aggression are known, means can be made to prevent aggression from happening, thus creating a safer society. This goal is the same in both discourses, and both staff and patients are included as subjects with responsibility for taking part in managing risk and achieving better safety for everyone.

The collection and management of personal information is not distinct to the ERM protocol alone. Collecting information has become increasingly present in modern society, and citizens now participate themselves in collecting information. As modern citizens, we are surrounded by technologies assigned to surveil our behavior and adjust it to being the best version of ourselves (Lupton 2021). This can be seen in most aspects of everyday life – students and workers have developmental conversations with their professors or leaders, every company one contacts wants to know how our experience with them has been, and we use technical devices such as cell phones and smart watches to track our steps, what we eat, and so on. The list of technologies of the self, both literally and figuratively, is endless, and healthcare services are no exception (Petrakaki et al. 2018). The ERM strategy is thus very much in alignment with governmentality-based power relations and technologies of the self. The patient is a citizen invited to discuss his inner secrets, unburden himself by telling the truth about his illness and his warning signs. However, like all collections of individual data, it has a flipside, because knowledge and power are interrelated. When we give our phone apps permission to track us, we also hand over the power of this knowledge to be used in, for example, targeted marketing. In a similar way, when a patient shares his valuable knowledge with staff in an ERM conversation, he takes the risk of this information being used for purposes other than decreasing the risk of aggression at the present moment. For example, the information might be used to argue in favor of involuntary treatment, although ERM is meant to contribute to the opposite; by means of the management of early warning signs, rehabilitation should be easier and safer.

In sum, our analyses of the two discourses show that the ERM protocol contains both conflicting and complementary aspects. Patients' contributions through participating in mapping early warning signs provide them, on one hand, with co-ownership of the subsequent treatment, thereby increasing their influence and participation. On the other hand, the ideology of involvement carries the risk that, instead of being subjected to visible paternalistic authority and control, patients internalize this control through the use of self-technologies. This self-management largely fulfills the same control requirements embedded in the more paternalistic-oriented medical discourse. Thus, what seems like patient involvement and increased power may actually involve subtle control and the exertion of power through self-management. Visible paternalism, which can be opposed, is replaced by a subtler form of self-governance that is more difficult to identify and resist.

5.4 | Practical Implications

In our view, it is crucial that healthcare staff understand the discourses surrounding their work situation and the potential impact of these discourses on how they think, speak, and conduct their work. Analyzing these discourses allows us to examine participation practices that, on one hand, can be seen

as liberating and empowering, yet simultaneously introduce new layers of control and self-regulation. These subtler mechanisms of control can threaten the subject's freedom and autonomy. The will to empower individuals through increased self-control aligns with society's need for risk management and control. This awareness can help health professionals strike a balance between the important role of advocating for patient rights, especially for vulnerable patient groups, and the responsibility for managing safety and risk toward society.

5.5 | Methodological Discussion

As our methodological tool for the analysis, we chose to draw on Hall's elements. However, the emphasis on the different elements was dependent on how the text represented itself and the elements' usefulness for presenting and discussing the findings.

Based on Foucault's discourse theory, Hall (2001) states that a discourse can never be based on one text alone; it is part of a larger and broader understanding of what is true knowledge at a given time – what Foucault referred to as an *episteme*. Our analysis is based on a single text; however, we argue that by analyzing the ERM Protocol, we may still uncover important aspects of the larger discourses and epistemes operating in the background of the discourses found in the protocol. This is relevant and important because this protocol is used in many European countries and has significant implications and importance. Additionally, its scope – mental illness, risk of violence, forensic psychiatry – is highly significant for both society and the individuals who use the plan (healthcare staff) and for those for whom the plan is intended to provide assistance (patients). Moreover, we claim that though it is a single text in a vast landscape of contemporary texts, it shares similarities with other texts that address the same subjects, found in, for example, government documents (Helsedirektoratet [The Norwegian Directorate of Health] 2013; Dahlborg Lyckhage et al. 2017; Stjernswärd and Glasdam 2022), health campaigns (Oute et al. 2015), or patient information (Boman et al. 2021; Ottesen and Strunck 2024). In that regard, analyzing and looking at it through a different lens than clinicians usually do is valuable.

The approach of our analysis was based on a critical examination of risk management strategies and the discourses surrounding them. Our goal has been to raise awareness about established truths "so that what is taken for granted is no longer taken for granted. To do criticism is to make harder those acts which are now too easy" (Foucault et al. 2002, 456). Foucault reminded us that power never ceases to exist, it just takes new forms. The power relations of our time might be of a softer, more "kind" type, but it is still power and should therefore always be made visible as an object of discussion and scrutiny.

6 | Conclusion

We have demonstrated that the two discourses of the ERM protocol are established through various power and knowledge components. The overarching goal of the plan is beneficial – to reduce the risk of violence. This benefit applies to patients who struggle to control their aggression and violent behavior and also to society as violence diminishes. Confinement and coercion represent forms of power that face skepticism and criticism. Modern psychiatry adheres to ideals of minimizing this type of exercise of power. In our efforts to explore these ideals, we have sought to demonstrate that combining scientifically based and participatory methods does not eliminate the exercise of power. Instead, power emerges in new ways and forms. This is evident in the analyses of participatory and empowerment strategies, which reveal that these approaches can also contain effective yet subtle forms of governance. While these strategies are intended to counteract and mitigate health professionals' objectifying expertise and paternalism, they also harbor potent forms of control. The clear control wielded by the powerful has been replaced by the subject's self-directed governance, built on technologies of the self. This phenomenon has been both observed and criticized in various contexts (Dean 2010; Karlsen and Villadsen 2008; Rose et al. 2006). We are reminded of the necessity of examining even highly desirable and highly valued changes toward participation and strengthened rights to remain vigilant to possible new and subtle forms of power, as well as elements of paternalism.

Ethics Statement

The research in is article is involving information freely available in the public domain, therefore no ethical approval has been sought.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

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