

# **USER INVOLVEMENT IN SCOTTISH MENTAL HEALTH POLICY: LOCATING POWER AND INEQUALITY**

*Lydia Lewis*

## **INTRODUCTION**

As in other parts of Britain, ‘user involvement’ – the active participation of service users in shaping or influencing services (Watson 1997) – has been a significant policy development within mental health services in Scotland in recent years (Scottish Executive Health Department 2000, 2001a, 2003a, 2003b; Scottish Office 1997; Scottish Development Centre for Mental Health [SDCMH] 2001). Alongside this has been a policy emphasis on the social control function of mental health services in Scotland, including as outlined in the new Mental Health Act (Scottish Executive Health Department Mental Health Division 2003). Other significant developments in mental health policy have been closely related to the Scottish social justice policy agenda, for example with a high-profile ‘anti-stigma’ campaign and attention to mental health ‘improvement’ (National Advisory Group for Improving Mental Health and Well-Being 2003) and, to a lesser degree, to the addressing of mental health inequalities (Scottish Executive 2001; SDCMH 2003a). Yet the fit between these different mental health policy initiatives in Scotland is far from clear and policy in this area may also be criticised for neglecting considerations of gender. This latter issue would appear

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particularly pressing in light of moves towards 'gender mainstreaming' within health policy at a global level (World Health Organisation [WHO] 1998) and the publication in England of the Women's Mental Health Strategy, and associated implementation guidance (Department of Health [DoH] 2002a, 2002b, 2003).

Arguing for the importance of analysing official policy discourses, this paper addresses these issues through a critical examination of discussions of user involvement in two current Scottish mental health policy documents that provide a framework for the development of services. Attention is given to the implicit assumptions underlying such discussions and the implications of these for the likely benefits of recent approaches to user involvement for those who use mental health services and for the advancement of mental health service provision in Scotland. Discussion centres on how service users are conceived of (or 'constructed') within the user involvement policy discourses, how this relates to gender and other areas of difference and inequality among users of mental health services, and on the location of power within the policy discourses. Consideration is also given to how other discourses within the policy documents may be incompatible with, or contradict, notions of service user 'involvement'. The paper concludes by considering how such user involvement policies within mental health services may be advanced, particularly by addressing issues of power and inequality and by ensuring that important social factors that contribute to experiences of both mental distress and using mental health services aren't overlooked, and how user involvement discourses may better accord with the important principle of social justice in the Scottish policy context.

## **MENTAL HEALTH POLICY IN SCOTLAND**

Mental health is currently one of the three clinical priority areas for the health service in Scotland (Scottish Executive Health Department 2000, 2003b). Policy in this area continues shifts away from hospital-based and towards community-based care provided under the Care Programme approach (CPA) and the development of mental health services in Primary Care settings is also receiving some attention (Scottish Office 1997; Scottish Executive Health Department 2000). Current Scottish mental health policy places the onus on the provision of services for those suffering what is referred to as 'severe and enduring mental illness', and the new Mental Health (Care and Treatment) Act 2003 (Scottish Executive Health Department Mental Health Division

2003) is set to introduce a number of important changes here, including the introduction of community-based compulsory treatment orders (CTOs). Suicide-prevention (particularly among young men) has also received great deal of attention in the Scottish mental health policy context in recent years (Scottish Executive 2001). Across all areas of mental health policy in Scotland, the advancement of user involvement in services has been viewed as central to service development (Scottish Office 1997, Scottish Executive Health Department 2000, 2001a, 2003a, 2003b).

Other recent developments in mental health policy in Scotland have related to mental health promotion and the reduction of 'stigma' associated with mental health problems (National Advisory Group for Improving Mental Health and Well-Being 2003). The issue of mental health inequalities has also received some attention in the context of the Scottish Executive's commitment to social justice – the addressing of social, economic and health inequalities in Scottish society (Scottish Executive 2001; SDCMH 2003a).<sup>1</sup> However, to date this area remains marginal, both to mental health policy in Scotland, and to the social justice policy agenda. Furthermore, considerations of gender have not been prioritised here (in contrast to recent related developments in England and Wales: DoH 2002a, 2002b, 2003), and recent policy relating to inequalities for health service users in general has focused on ethnicity (Scottish Executive Health Department 2001b).

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<sup>1</sup> *At the time of writing, the SDCMH had been asked by the National Programme for Improving Mental Health and Well-Being and the Scottish Executive's Equalities Unit to produce a resource document about inequalities in mental health to build on the issues raised at the conference, **Equal Minds: Addressing Inequalities in Mental Health** (SDCMH, October 2003).*

## **USER INVOLVEMENT IN MENTAL HEALTH SERVICES: THE SCOTTISH CONTEXT**

Enhancing the active involvement of mental health service users<sup>2</sup>, both in their own treatment and care and in the development of mental health services, has been a key theme in recent Scottish mental health policy (Scottish Executive Health Department 2000, 2001a, 2003a, 2003b; Scottish Office 1997). This move has been driven by both consumerist and democratic impulses, as well as by grass-roots organising among users of mental health services (the 'user movement'). Hence the purposes of such participation may be delineated as increased responsiveness of services to user need, as well as the promotion of user 'empowerment' (Barnes and Wistow 1991).<sup>3</sup> In Scotland user involvement initiatives are framed by social justice policies that are concerned with social inclusion in a broader sense (Scottish Executive 2003a).

In terms of the 'levels' of involvement afforded to users of mental health services, the Scottish Development Centre for Mental Health (2001) identifies these as individual (influencing your personal care and support), service (influencing organisations providing support) and strategic (influencing the planning of mental health services). At the strategic level, Barnes et al (1990) suggest a distinction between involvement at the level of local authority planning and policy development and at the national policy level. The different forms of user involvement have been categorised as campaigning (or collective advocacy), information/explanation, consultation,

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<sup>2</sup> (Service) 'user' has become the accepted term for those who are, or have been, in receipt of mental health services (Watson 1997), although others prefer terms such as patient, client, consumer or survivor (Mueser et al 1996). Barnes and Wistow (1991) outline a 'typology' of users that includes voluntary and involuntary users, short-term and long-term users and actual and potential users, and relate these to different kinds of user interests. Differentiation can also be made between users of different types of mental health services, such as those in the statutory, compared to the voluntary, sector.

<sup>3</sup> 'Empowerment' is an important concept in the field of user involvement, with varied and contested meanings. Whilst some have viewed it as a consequence of affording more choice and control to users, others have contested the view that power can be 'granted' to people, instead considering empowerment as a generative process 'in which people develop 'power to' take decisions, take actions, make choices, or work with others' (Barnes and Bowl 2001: 21).

participation (shared decision-making with professionals) and user control (Morris and Lindlow 1993; Morris 1997; Hickey and Kipping 1998). At the group level then, the forums and structures that enable user involvement may include:

- Local user groups, or user networks, the functions of which vary and can include campaigning and providing mutual support and a voice for users in the local area (e.g. the Highland Users Group or 'HUG').
- Patient's councils in in-patient facilities.
- Reference groups or forums of users and providers, which aim to implement national policy directives in the local context or to influence the development of local mental health services and policies.
- Users participating on national policy-making bodies (for example in the development of the new Mental Health Act 2003, in Scotland) or in national user consultation exercises (for example in the context of implementing this Act: Grant 2004).
- National user organisations such as the User Involvement Group in the Scottish Association for Mental Health [SAMH].
- Seminars, conferences and other initiatives that aim to promote user involvement in the mental health sector (for example those organised by the SDCMH 2001, 2003b).

In terms of the levels of influence achieved, to date, user involvement in national and local service planning and policy-making in Scotland has taken the forms of campaigning, information-provision and consultation, with 'shared' decision-making with mental health professionals tending not to be achieved (Loudon and Samuel 1999; Dean 2002). In addition, concern over the outcomes from various forms of user consultation in Scotland have been expressed (for example see Hardie 2003). However, there has been wide variability in the development of user groups and user involvement activities and forums across localities in Scotland and efforts are currently underway to form a national user-led user group for Scotland (Hardie 2003).

## GENDER AND MENTAL HEALTH POLICY

Gender is a central organising principle in relation to mental health services and is also key to our experiences of mental health and mental distress (Bondi and Burman 2001). Hence gender considerations are relevant to mental health (services) at the levels of 'concepts', professional practice and aetiology (the social 'causes' of mental health problems) (Busfield 2001). At the conceptual level, our perceptions of mental health and illness are gendered (Busfield 1996), and these have been shown to affect psychiatric diagnoses and treatment and referral practices (Borowsky et al 2000). For example, the dualisms rationality-irrationality, reason-emotion and stability-instability tend to be synonymous with conceptions of masculinity-femininity, and such gendered understandings can be linked to diagnostic patterns in psychiatry where women are twice as likely as men to be diagnosed with 'mood disorders' (Cermele et al 2001).<sup>4</sup> At the same time a current policy focus on 'severe and enduring mental illness' masks a gender dimension as diagnoses that are more often assigned to men than to women are more likely to be categorised in this way (Busfield 1999) and concerns about dangerousness are generally directed towards male (young and often black) mental health service users (Payne 1999). So whilst women have always been the predominant users of mental health services (Payne 1998), among psychiatric inpatients there have been changes in gender patterns in recent years, partly as a result of de-institutionalisation and other policy shifts.<sup>5</sup> At the level of professional practice, adult psychiatry remains largely male-dominated (Doyal 1994; Bondi and Burman 2001) and women have been shown to suffer particular forms of disadvantage within the mental health system (Payne 1998; Darton et al 1994). Lastly, in terms of the 'causes' of mental distress, socio-political and cultural factors that differentially affect the lives

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<sup>4</sup> *The numbers of women discharged from psychiatric hospitals in Scotland in the year 2000/2001 showed a marked gender pattern with 35% of women, compared to 21% of men being discharged with a diagnosis of 'mood disorder' and 9% of women, compared to 21% of men, with a diagnosis of schizophrenia (Information and Statistics Division [ISD] Scotland 2001a).*

<sup>5</sup> *In Scotland, male psychiatric inpatients began to outnumber females in 1998. In addition, age and diagnostic category are important variables here with an over-representation of younger men and older women and (as examples), about twice as many men compared to women with diagnoses of schizophrenia and one third more women than men with diagnoses of dementia (ISD Scotland 2000; 2001b).*

of women and men should be considered central (Coppock and Hopton 2000; Rogers and Pilgrim 2003). For example, community surveys such as the Scottish Health Survey (Scottish Office Health Department 1997) show that women can be up to twice as likely as men to suffer 'depression' and this is often attributed to women's oppression and the culturally constructed – and contradictory – expectations that frame their lives (Stoppard 2000).

However it remains the case that gender is often overlooked or dealt with inadequately in mental health policy (Bondi and Burman 2001). Women's voices have often been masked in relation to policy in this area (Alldred et al 2001) and gender bias and discrimination also often enter at the point of policy implementation (Busfield 1999). Furthermore, women are under-represented among increasingly powerful managers within the NHS (Payne 1998). It is due to such realisations that the recent Department of Health strategy in England, **Women's Mental Health into the Mainstream: Strategic Development of Mental Health Care for Women** (DoH 2002a) includes in its key messages that 'gender issues should be addressed in the application of the principles enshrined in the Mental Health National Service Framework' and that 'involvement and listening to women should be fundamental to all service planning, delivery and evaluation' (p.29). Here it is important to recognise that such listening to women and attention to gender as a relevant social dimension has the potential to contribute towards the progression of mental health service provision in general (Stefan 1996; DoH 2002b). Considerations of gender should also be central to policies and initiatives surrounding mental health inequalities and mental health promotion.

## **SELECTION OF POLICY DOCUMENTS AND METHODS OF ANALYSIS**

The two Scottish policy documents that are considered here are the (national) **Framework for Mental Health Services in Scotland** (Scottish Office 1997), which sets out a template for the development of locally-based mental health services across Scotland between 1998 and 2004, and a local interpretation of this, '**New Horizons – A Joint Endeavour**': **A Framework for Mental Health Services in Grampian** (Grampian Health Board 1998), which puts forward a regional strategy for the development of mental health services within the same timeframe. The focus of the analysis is on aspects of

the policy documents that deal with, or seem particularly relevant to, user involvement.

The policy documents were selected for analysis because user involvement is an important theme running throughout them both. In addition, the national Framework has been a highly influential document and in recent years has served as the main point of reference for those involved with developing mental health services in Scotland. The local response to the Framework was sampled in order to address the issue of how national user involvement policies are interpreted for use in the local context and as part of a wider study of user involvement activities within mental health services in the Grampian region (see below). However, whilst the two policy documents apply to Scotland and Grampian respectively, equivalent documents exist for other parts of the UK and for other regions of Scotland, and so the analysis is relevant beyond the geographical regions for which these specific policy documents were developed.

The analysis presented here is part of a wider study of user involvement activities in mental health services in the Grampian region. The policy documents were analysed as part of this study as they formed the basis of the development of a number of user involvement initiatives in the local area, including the formation of a local user group, a user consultation exercise and the participation of users in a local planning forum to implement the local Framework document. Hence it was considered important to analyse these documents as they provided a foundation for the development of policy initiatives surrounding user involvement and so were considered likely to provide insights relevant to the understanding of associated practices. However policy documents such as these should also be considered worthy of analysis in their own right, since the discourses contained within them may be seen to both reflect and construct the practices with which they are concerned. Such documents are reflective of current perspectives on and understandings of policy issues among those who both produce them and are responsible for their implementation – policy makers and managers at the national and local levels – and are also likely to be derived in part from current practices in the area. The policy discourses contained within such documents are therefore constructive of practices as they are implemented and also as they come to be promulgated in public spheres and to infuse the language used in specific public policy or service areas.

The documents were analysed using a discourse-analytic approach that viewed discourse as a way of understanding (or a set of ideas about) a particular phenomenon. Discourse analysis is concerned with how language constructs and creates social life. It emphasizes the role of language in producing our ways of thinking about (and therefore of acting and being in) the world. In particular discourse analysis is concerned with how power operates in and through language (including through the manners in which people are conceived of and 'positioned' within this) – in other words with how discourses *work* to construct and bring into being (or constitute) social relations of power and ordering. The approach can be applied to a variety of discursive forms and many have pointed to its value as a tool in social policy analysis (for example, see Payne 1999).

The discourse analytic approach employed here draws on Gill (1996, 2000) in order to consider hidden or underlying assumptions ('subtexts') within the policy discourses in relation to user involvement, as well as silences within the discourses (what is not said as well as what is said) and their social functions and consequences, including in relation to the interests they serve. This also meant considering contrary interpretations the policy discourses seemed designed to counter and relationships and contradictions between different discourses within the texts and between the two policy documents analysed. Specific focus was placed on gender as a lens for analysis. Interpretation then centred on the implications of the analyses for the meaning and value of user involvement policies within mental health services.

## **IMPLICIT ASSUMPTIONS WITHIN USER INVOLVEMENT POLICY DISCOURSES**

### ***Users of services form a coherent and homogeneous group of individuals that can be consulted for their views***

Some of the main problems often associated with the discourse of user involvement in mental health services relate to its homogenising and pathologising effects (Forbes and Sashidharan 1997; Orme 2001 2002) because it 'conceives of people primarily in terms of their relationship to services' (Beresford 2000, p.489). Such effects were evident from the discursive construction of the 'service user' within the two policy documents examined here. Within the national policy document there is repeated reference to 'people with mental health problems' and 'involving people who

receive services and those who care for them' (Scottish Office 1997, pp. 7, 11, 14) and, particularly in the local document, to the (generic) service 'user'. The primary grounds on which service users are seen to differ is in relation to their 'type of mental health problem' (Scottish Office 1997, p.2).

The national policy document does provide some acknowledgement of differing interests and needs among those who use mental health services, based on social and cultural positionings, including in relation to gender. For example, it states that 'self determination should be promoted by [amongst other things] addressing the special needs of women' (Scottish Office 1997, p.3). At the level of service planning and development, there is reference (in an appendix) to the importance of 'engaging with a broad cross-section of people who use services (including older people, women and those from black and ethnic minorities)' (op cit, Appendix 2, p.6). However, there is no discussion of *why* it is important to consider the views of women and the other stated groups, and in many ways this brief mention is incompatible with the over-riding user involvement discourse which does not acknowledge that there may be different or competing perspectives according to social positionings. How such a recognition of difference fits with the notion of involving 'representatives of service users' (op. cit, p.12) is not considered, and the practical implications of asking someone to represent a group that includes varying (and not necessarily complementary) interests remains unaddressed.

That issues of diversity and inequality among those who use mental health services are only given a fleeting mention in the national policy document, which is supposed to provide guidance for the development of local services, also means that such considerations can evaporate by the time they reach the local level of interpretation and application. This is certainly the case with the Grampian Framework document in which discussion of 'inequalities in mental health status' and 'wider influences on [mental] health' (Grampian Health Board 1998, p.19) do appear, but without consideration of their implications for user involvement. Thus the means by which women service users may have been enabled to develop a stronger voice in relation to mental health service planning become curtailed at the point of local policy translation.

An attempt is made in the documents to deal with issues of diversity and difference among users of mental health services in terms of individuation at places where 'individual' compared to 'collective' representation is

discussed. For example, in relation to advocacy, it is stated that ‘as well as enabling individuals to develop their own roles, people should be enabled to develop a role as a service user or carer representative’ (Scottish Office 1997, p.17). However, the differences between these two forms of involvement are not fully explained and in any case making a distinction between views of ‘individual’ service users and those of ‘representatives’ of service users still leaves the issue of differentiation and inequality between (the expression of) views and experiences among users of mental health services unaddressed.

The overall effect of this policy discourse of user involvement, then, is to pathologise, individualise and homogenise the experiences of users of mental health services, thereby constructing a disempowered position for the service user to ‘take up’ and act within. Constituting users as a homogeneous group of individuals who only meaningfully differ in terms of the ‘category’ of mental health problem suffered serves to construct the mental health service user as ‘other’, ‘conceal[ing] notions about normality and deviance’ and marginalizing the position from which service users are able to speak (Forbes and Sashidharan 1997, p.492). The construction also means that attention is diverted away from important socio-political factors that contribute both to experiences of mental distress and of mental health service usage (Means and Smith 1994); the user involvement discourse works to reify medicalised understandings of distress and to eclipse alternative social conceptions of these. Issues of diversity and inequality among users of mental health services therefore become overlooked in relation to user involvement, even when they are given consideration at other points within the texts, because the discourse ‘encourages a denial of other sources of disadvantage and discrimination, such as gender, class and race, and the implications of this for user empowerment’ (Means and Smith 1994, p.76).

### ***The appropriateness of existing service provision and structures***

Although ostensibly promoting and enforcing ‘user involvement’ in mental health services, what really prevails in the policy documents is a ‘consultation’ model of participation. This is evident in statements such as that service users ‘should be *invited* to take part in development of the [local] strategy’ (Scottish Office 1997, p.5, emphasis added) and ‘views of ... people who receive services ... must be incorporated [into processes of service development]’ (op. cit, p.12). Implicit within this model is the expectation that users ‘fit in’ with existing services and planning forums in terms of their expression of views and participation. However there are ambiguities within the policy discourse in terms of the ‘level’ of involvement afforded to service

users since in both documents there is reference to 'involvement', 'participation', 'self-determination' and even 'empowerment' in places as an attempt to convey the impression of meaningful involvement is made.

In relation to user involvement in individual treatment decision-making, there also seems to be an unchallenged assumption within the policy discourses that power should remain with psychiatric professionals. This is evident in the statement that users should be 'involved in the management of their care ... where clinically appropriate' (Grampian Health Board 1998, p.11). It is reinforced, as well, through the discursive construction of a passive service user, for example in the statement that services should ensure 'an early recognition of, and appropriate response to, those with a serious mental illness' (Scottish Office 1997, p.6) and the notion of service users 'passing through the system' (Grampian Health Board 1998, p.17).

At the level of service planning too, there is suggestion that there should be 'involvement of all stakeholders at appropriate levels' (Scottish Office 1997, p.5), with the clear assumption that what is 'appropriate' will be decided by those who are in existing positions of power. Evidently the number of 'stakeholders' involved means that it would be very hard for users, and particularly for women, who are likely to be outnumbered by men in planning circles and who also tend to suffer a 'credibility problem' (Stefan 1996) in such circumstances, to play a significant role in relation to the local implementation of the policy. However, there is little or no acknowledgement of this as the idealistic notion of a 'partnership' approach that 'involve[s] all key players' is advocated (Scottish Office 1997, p.10).

Some acknowledgement is given in the local policy document to 'the unequal power relationship in mental health care' (Grampian Health Board 1998, p.17) and how this can act as a barrier to user involvement. However, there is no reference to structural factors other than one's (undifferentiated) position in relation to the 'service' when considering such power relationships. What's more, these are presented as an inevitable facet of service structures that 'service users and carers will need support and training to overcome ... [and] cope [with]' (op. cit, p.17). In this manner the discourse avoids the issue of barriers to involvement at the level of organisational structures and culture through redefining these in procedural terms and locating the 'problem' with the (generic) service user or carer.

Thus the emphasis in the user involvement policy discourse is on 'obtaining' and 'incorporating' the views of service users into current systems rather than

allowing the possibility of real challenge to existing ideas about service provision, and in this manner the discourse counters any notion of devolving power away from service providers. This occurs as well in discussions of user involvement at the level of individual service usage, where the dominance of medical approaches, and thus the patriarchal nature of the mental health system, is justified by the discourse. However ambiguities within the policy discourse about the level of involvement afforded to service users also evidently hold the potential to lead to problems of the raising of expectations among service users who are attempting to exert an influence within mental health services.

### *The value of focusing on individual needs*

Another discourse that can be identified within the policy documents centres around the paramount ethical principle in social work of respect for persons (Orme 2002) and a service focus on individual need. Here the national document notes the importance of meeting 'the needs of the individual' (Scottish Office 1997, p.5) and also states that services should 'value the individual [service user]' (op. cit, p.3) and 'meet the assessed needs of those individuals who have mental health problems' (op. cit, p.6). Within this discourse, the conception of the individual with 'complex, enduring and variable needs' and who 'require[s] additional treatment and support' (Scottish Office 1997, pp.8, 13) is also conveyed. However whilst this may be regarded as an important attempt to avoid a 'one size fits all' approach to mental health service provision and to recognise the value and uniqueness of each individual who comes into contact with the service, there are also evident problems with the discourse when viewed in the context of user involvement.

Although the discourse implies that services will be centred around the needs expressed by the service user, it in fact serves to legitimate professional control over (the assessment of) these needs. This means that needs are redefined in terms of what services can offer (Forbes and Sashidrahan 1997), providing 'a neat solution to the problem of potentially limitless demand for "needs-led" services, but one that sits uneasily alongside the consumerist rhetoric of [community care] reforms' intended to promote choice and self determination (Means et al 2003, p.158). Within such an approach consideration of the social causes of such 'needs', which are much harder to tackle at the policy level, is also avoided. The discourse therefore has the effect – similar to that of 'user' involvement described above – of decontextualising and depoliticising the experiences of those who come into

contact with mental health services, thereby constituting a disempowered service user. In the words of Orme (2002) 'in concentrating on, attending to, and hopefully alleviating individual need, there is no political awareness or critique of the situations which contribute to the need: justice is constrained' (p.805).

The construction of the 'needy' individual with 'complex needs' that should be met through heightened service intervention could also be considered paternalistic and patronising, leading to an over-pathologised view of the service user (Stockdale et al 2000). Again, the notion is disempowering to those who use mental health services, including women (Gammell and Stoppard 1999), and can lead to a denial of their autonomy and agency (Orme 2002). Viewed as well in the context of gendered conceptions of women psychiatric patients as passive and over-dependent and male service users as requiring supervision and control (Busfield 1996), they seem particularly unhelpful to the furthering of user involvement initiatives.

#### *A masculinised conception of the service user*

There are also other underlying gender assumptions in the two documents that have implications for understanding the user involvement discourses used. Notably, the policies state (in bold) that the overriding emphasis for mental health services should be 'individuals with severe and/or enduring mental health problems, including the small number who present either a danger to themselves or to others' (Scottish Office 1997, p.2). As already discussed, such an emphasis has a clear gender dimension because diagnoses, such as schizophrenia, that are more often assigned to men than to women tend to be grouped under this umbrella (Busfield 1999). In addition, fears about dangerousness are also more likely to be directed towards male psychiatric patients (Payne 1999). Hence this focus upon 'individuals with severe and enduring mental health problems', along with the generally 'degendered' discourse about user involvement, evokes a masculinised conception of the 'service user', with whom mental health professionals should be concerning themselves, including in relation to 'involvement'.

The national policy document qualifies its focus on 'severe and enduring mental health problems' by stating that 'a local mental health service should seek to address the full range of needs of all people with mental health problems' (Scottish Office 1997, p.2). It also later states that 'as mental health problems range from moderate distress and anxiety to severe and/or enduring problems, clarification is required about whose needs are best met

in which setting' (op. cit, p.7). However this last sentence could be construed as down-playing women's forms of suffering, whilst this 'needs-based' approach helps justify a policy focus on dangerousness among (male) psychiatric patients. Thus for women service users, the policy discourses present a double-edged sword, drawing the psychiatric gaze (and its pathologising effects) away from their experiences of mental suffering, but also away from prioritising services to help them. Conversely, the discourses focus attention on male users of mental health services, but not necessarily in a manner likely to enhance their active participation or influence.

### *Competing and contradictory discourses*

The difficulties of reconciling user involvement policies with the social control imperative of mental health services have been much discussed (for example, see Chinman et al 1999) and this also represents an important point of disunity within the policy documents studied here. An over-riding concern for the social control of service users is evident from the policy emphasis on 'dangerousness' among (mainly male) users of mental health services, as described above. It is also present in the discourse of the local policy document regarding 'maintaining people' within employment and the community (Grampian Health Board 1998, p.20), 'reintegration of individuals into society' (op. cit, p.22) and 'assertive outreach' which should be 'targeted on those with severe and enduring mental illness' (op. cit, p.30).

This conception of the mental health service user as 'dangerous and different' (Payne 1999) is reinforced by the needs-based discourse described above, and also by the dominance within the texts of medical constructions of 'mental illness' (or 'mental disorder', as it is often referred to). Hence there is another discourse here that works against notions of enhancing meaningful user involvement – that of mental illness. As several feminist authors have pointed out, such a dominant psychiatric paradigm has the disempowering effect of individualising and pathologising experiences of mental distress (eg see Foster 1995) and is also incompatible with personal empowerment (Gammel and Stoppard 1999). So whilst alternative 'social' perspectives of distress do appear within the policy documents, the value of these is countered by the discursive authority afforded to medical approaches, and their implications for user involvement are also not considered.

Thus several discourses compete with or seem to contradict that of user involvement in the policy documents. A discourse surrounding the social control of (male) service users means it is hard not to get the impression from

them that a subtext of surveillance and regulation (rather than the stated self determination and empowerment) is the intended aim of 'user involvement'. Moreover, if user involvement (or user consultation) policies are considered to feed into the other policy objective of allaying public fears about risk and dangerousness among psychiatric patients in this way, it becomes even more evident why these are likely to focus on the male experience of using mental health services. Contradictions inherent in attempting to afford a meaningful role to service users in services still dominated by a medical paradigm of mental illness are also present.

### **USER INVOLVEMENT POLICIES: CONTRIBUTING TO SERVICE DEVELOPMENT?**

Having pointed out several absences, hidden (and problematic) assumptions and inconsistencies in the policy documents examined, it is necessary to consider the implications of this analysis for the benefits of user involvement discourses in terms of advancing service provision for women and men experiencing mental distress. Here it would seem that the main value of the user involvement policies lies in their drawing attention to the important moral imperative of affording a more active role to users in all respects of mental health service provision, and in providing a necessary precept for wider processes of change and raising consciousness. The policies also constitute a 'lever' by which users can demand a more active role in service planning and, in their implementation, provide a vehicle for users to express their views. However, it remains apparent that the short-comings and contradictions of the user involvement policies mean these are unlikely to lead to significant improvements in mental health services in Scotland, particularly for women.

Firstly, the absence of discussions of gender (as well as of ethnicity, class and other social variables) in the user involvement policy discourses mean that important dimensions of power and inequality are overlooked. The patriarchal nature of psychiatry has often been shown to be the source of unhelpful responses to women's mental suffering in the past (Foster 1995), and user involvement policies do nothing to acknowledge or tackle these fundamental ideologies and power relations. Indeed, through their failure to challenge gender-neutral assumptions about the provision of such services, they may further entrench and justify gender inequalities in the discursive and structural organisation of these (Croft and Beresford 1992). The emphasis in

the policies on 'severe and enduring mental illness' also means that user involvement discourses in the mental health policy documents seem to mask a social control imperative of user involvement initiatives directed in particular at male service users. In so doing, the discourses inadvertently privilege the male experience of using mental health services, contributing to further denial of women's needs and voices and to further invisibility for women in the mental health system.

As well as the failure to consider social inequalities such as gender in relation to user involvement, the policies also neglect to explicate their 'model' and goals of involvement, and how these relate to the medical and social models of mental health, which are both present in the texts. Ambiguities and contradictions both between and within discourses means that the rhetoric of user involvement often appears to have more to do with incorporation and control than democratisation and empowerment, and this is perpetuated through what Orme (2002, p.809) has called 'the restrictive bureaucratisation of confining those who require care ... into constrained homogenized categories of, for example ... those with mental health problems'. Not only can this lead to the denial of other sources of disadvantage such as gender (Means and Smith 1994), but it also means that user involvement discourses can act as a smokescreen to more meaningful change at the organisational and cultural level of mental health service provision that would involve re-evaluation of different actor's contributions, including in relation to those of women and men (cf Cockburn 1991). The discourse also achieves this through its focus on the training and support of service users to contribute towards the development of service provision, rather than on the conditions which would facilitate their participation.

According to Forbes and Sashidrahan (1997), such contradictions mean that user involvement policies are structurally unable to go beyond 'providing a voice' and failure to engage with issues of unequal power relations means that the only likely outcome of such an approach to involvement would be to legitimate and perpetuate current forms of mental health service provision and service relations (Williams 1995). Furthermore, within such a consumerist approach,

it will be very difficult ... to raise the larger and perhaps more pertinent questions concerning the structural position of particular groups of people within society, which in turn provide an understanding of their experiences within specific services. Unless such questions are raised, an

enquiry concerning the roots of inequality as seen within services will continue to be dominated by an understanding of the procedures and practices within it (Forbes and Sashidrahan 1997, p.493).

That the user involvement discourses are still premised upon medical conceptions of mental illness also means that they help perpetuate and justify dominant psychiatric discourses, and counter alternative interpretations of mental distress. Their focus on individual need can also result in discourses contributing towards a constraining of political awareness of how such needs have developed (Orme 2002). Such critiques have been central to feminist analyses of psychiatry, which also point out the incompatibility between medicalised understandings of distress and women's empowerment. However, the dominance of user involvement discourses means such issues are in danger of being overlooked in current debates in Scotland about mental health service provision.

## **WAYS FORWARD FOR USER INVOLVEMENT POLICIES**

Evidently policy-makers may be motivated to keep discussions of conflict, or potential conflict, both between and among users and providers of mental health services off the political agenda. Indeed, the overlooking of complexities and contradictions in this area may be seen to be facilitated by 'user involvement' discourses, as service providers and policy makers have been reluctant to embrace the true challenges posed by the enhancement of service user influence in developing mental health services. Yet clearly if user involvement policies are to be advanced in Scotland, and to avoid the often-described 'implementation deficits' in this area, policy initiatives that recognise the fundamental issues concerned are required. This renewed approach, I would argue, needs to challenge and disrupt current dominant policy discourses associated with user involvement, and also to consider in more depth the practical and material prerequisites and institutional and cultural conditions for enabling meaningful participation of service users in their interactions with mental health services and in service planning structures.

### ***Addressing issues of power***

If, as suggested by Florin and Dixon (2004), 'genuine [patient and public] involvement requires transfer of power' (160), it would seem necessary for user involvement policies to engage with this issue. From a policy

perspective, this would mean acknowledging that service users 'have continued to occupy a disadvantaged position within a rhetoric of user empowerment', with the power of professionals and agencies remaining largely unchanged (Means et al 2003, p.157), and that this disempowered position inhabited by many mental health service users comes from their having been 'inducted' or even forced into using services, rather than this being a matter of consumer 'choice' (Forbes and Sashidrahan 1997). In place of ideological discussion of 'involving all key stakeholders' would need to be recognition and understanding of the marginalized and disadvantaged position from which many service users are attempting to become 'involved', and how this relates to both (gendered) power relations within services and the larger socio-political context. This would become an important first principle for meaningful involvement from which consideration of the implications for the meaning and mechanisms of user involvement would necessarily follow.

Implicit here are two further issues that would need to be tackled: conceptualisations of power (many would argue that control over services is not simply a zero-sum game) and whether underlying policy assumptions of user involvement being a 'win-win' situation for users and providers, whose interests do not necessarily converge, is realistic. At the very least, this would entail user involvement policies being clear about the goals of involvement and the limitations of what can be achieved in a consumerist approach (see Tritter et al 2003). Recognising that power operates through the construction of service users (Servian 1996) and so needs to be 'taken' not given (Oliver and Postance 1995) would mean such policies should also be careful not to confuse user involvement with ideas about empowerment and liberation in the mental health field in order to avoid policies leading to unrealistic raising of expectations about their potential for reforming services (Croft and Beresford 1989). As stated by Means and Smith (1994, p.98), 'clarity about the degree of influence on offer is essential since people need to know the scope and limits of the contribution they can make. If people are to contribute effectively, they need to know what it is they are expected to contribute and what the outcome will be'.

Means and Smith (1994) also point out that access to information and participation in decision-making are not realistic strategies for user empowerment and so user involvement initiatives should ensure strategies of 'exit' as well as 'voice'. This would entail recognising the need for alternative forms of service provision, and for other forms of collective advocacy and

organising (including women's groups and services: see NIMHE 2003) among those who align themselves with the politics of the mental health service user movement. This is particularly the case since many would argue that the most important role and contribution of user groups in mental health services is to challenge and provide alternatives to psychiatric approaches. Acknowledging, implicitly at least, that facilitating connection with wider political struggles is likely to hold more empowering or liberatory potential for many 'service users' would also be helpful here (Coppock and Hopton 2000; Forbes and Sashidrahan 1997).

Lastly, engaging with issues of power would require recognition of the barriers to involvement in terms of service structures and cultures and control over the 'rules of the game' (Barnes 2002), rather than focusing on 'training and support' for individual service users. As pointed out by Orme (2002, p.810), 'rights should not have to be asserted by those with the least power ... conversation needs to be held in conditions which allow the least powerful to articulate their rights – and be heard'. Consequently, in order to allow users an input into decision-making, service planners and providers need not only to change their decision-making processes and to provide a variety of 'mechanisms' for input from a multiplicity of users (Means and Smith 1994), but also need to consider these in the context of (patriarchal) institutional cultures which may be oppressive, especially to women service users.

### ***Centring issues of difference and inequality***

Disrupting the notion of the generic 'service user' in policy documents such as these by locating considerations of gender and other forms of difference and social inequality, for example ethnicity and social class, as foreground to user involvement policy discourses would also seem important. Such a shift of emphasis would help counter the homogenising effects of the user involvement discourse and help further meaningful involvement by acknowledging how social positionings contribute to experiences of both mental suffering and service usage (and therefore of 'user involvement'). Here it is important to recognise as well that there are likely to be common views and experiences among users of mental health services so as not to undermine the position of user groups within the sector (Orme 2001). But an approach to user involvement that 'explicitly recognises and encompasses inequalities of power and diversity of experience and expression rather than assuming that such inequality and diversity will be accommodated within processes governed by universalist notions of fairness and competence'

(Barnes 2002, p.324) is essential if the social underpinnings of experience in this area are not to be overlooked.

Hence considerations of gender need to be made visible here if they are to be tackled (WHO 1998; DoH 2003). In terms of furthering user involvement, this would require acknowledgement of the gendered nature of relations of power and ordering in mental health services and the consequences of this for the participation of women and men who use services (see DoH 2003, pp.14-19 for specific recommendations). It would also necessitate a shift to a perspective of mental distress more firmly embedded in a social model, which would then demand a focus on political as opposed to merely individual aspects of experience. Within this context, gender-specific user consultation exercises are likely to play an important role (see NIMHE 2003 for a further example).

At the individual level of receiving services, it is clear that a gendered understanding of, and response to, women's mental distress is required in order to ensure that women feel listened to and involved and to counter the individualising and pathologising effects of many policy discourses surrounding 'individual needs'. The provision of services based on the needs of individuals continues to be central, but, as pointed out in the Women's Strategy implementation guidance (DoH 2003), this should be '*informed* by an understanding of gender and other dimensions of inequality' (p.10) for women want taken seriously their understandings of their distress as rooted in the context of their lives (DoH 2002a; 2003). Similarly, in terms of women service users' involvement in the planning and development of mental health services, the DoH policy documents take an important stance by acknowledging that whilst there are differences between women, which need to be taken into account in order to avoid a homogenising and potentially damaging view of women service users, women also often share certain aspects of experience and therefore interests, and it is these that can be drawn on to further the development of mental health services for women. Mental health policies in Scotland could undoubtedly also benefit from this recognition.

### ***Countering the dominance of psychiatric approaches***

The central contradiction in policy documents such as those examined here lies in their perpetuating and reinforcing the dominance of psychiatric approaches on the one hand (in which control over conceptualisation of and response to mental health problems is taken out of the hands of the service

user) and user involvement or empowerment on the other. This contradiction, I would argue, can only be overcome by a fundamental shift in mental health policy to an underpinning with acknowledgement of the underlying socio-political context of mental distress, 'to a frame of reference which accepts and recognises the importance of social and material circumstances in shaping men's and women's lives and their mental health' (Coppock and Hopton 2000, p.102). This would not require an abandonment of psychiatric approaches, since these do not necessarily eschew such a recognition (Busfield 1996). But it is the dominance of psychiatry as a profession, and of psychiatric understandings and responses to mental and emotional suffering, that need countering through policy discourses (and other means) since these, nevertheless, encourage a denial of social understandings of such personal troubles.

As a male-dominated profession, the authority still afforded to psychiatry is particularly problematic for women service users who have often complained about unhelpful professional responses involving 'their mental health issues [being] discounted as "women's problems" and a refusal by professionals to recognise any relationship between their family and social lives and their mental ill-health' (DoH 2003, p.21). For all service users there is often a recognition of the need to disrupt the dominance of medical understandings of 'mental illness', which in turn structure policies and services, and to legitimise less oppressive alternatives. User involvement policies therefore need to ensure recognition and understanding of these alternative conceptions of mental health and distress – and to consider their implications for the policy process. As pointed out by Barnes (2002, p.323), 'if the bearers of such knowledges are to be included within processes previously determined by rules governing dialogue on the basis of scientific evidence, bureaucratic procedures and/or party political debate, then this may require rethinking those rules in order to accommodate them'. How to afford discursive authority to individual and 'lay' experience of mental and emotional distress in formulating mental health policy would be a central consideration here (see Little et al 2002).

#### ***'Rights' more than 'needs'***

Lastly, user involvement policies could avoid some of the contradictions in their approach through emphasizing rights as well as a needs, which would be more compatible with notions of involvement and is essential for user empowerment (Means and Smith 1994). Extending this approach would entail moving beyond a view of rights in terms of individual autonomy (see

Scottish Office 1997, p.3) to a conception of social rights (Coote 1992) which could include rights to express needs (Orme 2001; 2002), rights to be heard and understood (Young and Quibell 2000; Little et al 2002) and rights to full societal participation (Coote 1992). This redefinition of 'service users' as 'citizens with rights' (Carling 1995) would be consistent with the current social justice policy agenda in Scotland, which underpins much mental health policy. It would also aid links between the user movement and wider political struggles associated with addressing the underlying social and political 'causes' of distress (Coppock and Hopton 2000; Forbes and Sashidrahan 1997) whilst helping eschew notions of deviance and otherness in relation to users of mental health services. This latter issue is of increasing urgency in a climate of heightening fear and control in mental health services (Perkins 2001; Pilgrim and Rogers 2003), and with the introduction of the new Mental Health Bill in Scotland (Scottish Executive Health Department Mental Health Division 2003) which extends the compulsory powers of services.

## **CONCLUSION**

User involvement policies in mental health services in Scotland have a long way to go. The analysis presented here suggests that furtherance of this policy initiative rests on a reappraisal of the principles underlying current conceptualisations of 'user involvement', as well as more in-depth consideration of the coherence between varying, and often competing, mental health policy discourses. One of the main challenges for user involvement policies is how to acknowledge and encompass diversity and inequality among users of mental health services whilst retaining the general imperative of affording a more active role to users of services and not undermining the efforts of mental health service user groups. Required, therefore, is an approach to user involvement similar to what Lister (2003) has called 'differentiated universalism' i.e. a perspective which recognises both the shared and differentiated positions and experiences among users of mental health services in terms of power relations and use of services. In order to contribute towards furthering the Scottish social justice policy agenda, therefore, policies for the involvement of mental health service users need to be (re)formulated in the context of socio-political factors associated with mental distress and with experiences of using mental health services rather than stopping at simply ensuring the provision of mechanisms for users to give their views. They also need to encourage forms of involvement (and consultation) that view mental health inequalities – including in relation to

gender – as central considerations from which more general recommendations for service development can ensue. Encompassing recognition that overcoming the ‘medical dominance of service provision ... [is] critical to the pursuit of a more humanitarian approach to mental health issues’ (Chapman and Goodwin 1992, p.97) and emphasizing the rights of service users would be additional important principles in this approach.

Overall, then, user involvement policies need to engage with issues of power and inequality both among users of mental health services and between them and providers, and to consider these in relation to understandings of mental and emotional suffering. Addressing gender as one important dimension of power and inequality should be central to such initiatives, and the DoH guidance (2002a; 2002b; 2003) has set an important precedent here. This guidance, in addition, provides a good example of how to ensure that the voices of service users are present in, and constructive to, the production of mental health policy documents. Such a proactive approach to involving service users in the development of mental health policies and services is ever more pressing considering the urgent need to improve the kinds of help available to women and men experiencing mental distress.

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