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Mental health and human rights:
A common agenda for user/survivor and women's groups?

Abstract

Mental health is set to be an important agenda for the new Equalities and Human Rights Commission in the UK, providing a significant opportunity for coalescing the work of mental health service user/survivor and women's groups. In this context, this paper examines the relationship between these groups, which has been marked by both convergence and contestation. Drawing on a study of mental health service user/community groups in one locality, it explores some of the ideological and identity issues which require working through in order to achieve a common agenda for change.

Key words: mental health; human rights; user/survivor movement; feminism

Introduction

The formation of the new Equality and Human Rights Commission (EHRC) in the UK brings together the former Racial Equality, Equal Opportunities and Disability Rights commissions. A growing national and global mental health crisis (DRC Mental Health Advisory Group, 2007) and its previous marginalisation within the disability agenda (DRC, 2007) means mental health is set to be an important concern for the Commission across equality and diversity strands (DRC Mental Health Advisory Group, 2007), with a focus on social responses and social inclusion issues (Diamond, 2007; DRC, 2007). Since it has a role in influencing public policy, including through working with the voluntary and community sector, this opens up new possibilities for mental health politics, including the opportunity for coalescing and strengthening the work of

user/survivor¹ and women's groups. However, whilst these two groups share certain political and ideological aims, and their organising has been marked by convergence, there are also points of tension between them and they have been brought into opposition at times. Drawing on a qualitative study of mental health service user and community groups in one British locality, this article explores these tensions and highlights the challenges and opportunities for the two in working together for change. I begin with a brief overview of the current U.K. mental health and human rights agenda, and then a discussion of user/survivor and women's organisations as social movements in mental health.

The mental health and human rights agenda

The political dimensions of mental health and mental health services, and associated government policy, are broadly what constitute the current mental health and human rights agenda in the U.K. The politics of mental health centre upon inequalities, including socio-structural inequalities of class, gender, 'race', ethnicity, age and sexuality, and issues of power, abuse of power and violence (Tew, 2005). Tying to this, the politics of mental health services are concerned with paradigms which recognise to a greater or lesser extent these political dimensions of distress, and debates over medicalisation (Williams, 1996; SPN, 2003). They are also concerned with the operation of power within mental health services and experiences of these as empowering or oppressive for users (see, for example, Williams 2005).

In this context, mental health policy is a contested domain, since it is a major influence on public health responses to mental health and distress as well as the forms and approaches mental health services take (Payne, 1998). Since the 1980s, there have been

a series of major policy changes in the U.K., many of which have been framed in terms of the rights of service users. These have included deinstitutionalisation and a shift towards community care, as well as ‘user involvement’ in services – a policy drive borne out of both consumerist and democratic impulses, including political organising among users (Campbell, 1999). Recently, there has also been a new onus on social and economic rights issues in relation to social inclusion and reducing mental health inequalities (DoH, 2003a; Social Exclusion Unit, 2004). This has encompassed attention to matters of socio-economic disadvantage, age, race and ethnicity (see also DoH, 2005), and gender, which in England has seen the production of a *Women’s Mental Health Strategy* (DoH 2002, 2003b). Across all of these areas ‘mental health promotion’ has been propounded alongside improving services (DoH, 1999).

Yet, at a service and policy level, a number of human rights concerns remain. In the first instance, there is the issue of whether policies such as user involvement are realised in practice (Wallcraft, 2003). Furthermore, a central point of contention is that the dominant paradigm for the provision of mental health services in Britain continues to be a medical one, with psychiatry retaining its central position within the structure and social care services remaining the poor relation (Payne, 1998; Duggan, 2002), and even social concerns about mental health and distress becoming framed in individualised and medicalised terms (Beresford, 2005). It is also a point of contention that alongside drives towards user involvement, social inclusion and addressing inequalities, mental health policy includes increasing imperatives towards coercion and control within a climate of fear and risk to public safety posed by service users (Beresford *et al.*, 2002; Beresford, 2005). These imperatives have recently culminated in the introduction of controversial new mental health legislation which extends the compulsory powers of

services beyond in-patient treatment to the community (DoH, 2007; Scottish Executive, 2003). All of these issues have been pursued by social movements in mental health, often within an explicit human rights framework.

Social movements in mental health

Social movements are “certain groups engaged in informal efforts in order to promote their interests in opposition to dominant forms of power and organisation preferred by the state” (Rogers and Pilgrim, 1991: 130, following Toch, 1965). Since they have both been concerned with the provision of mental health services and with wider social conditions relating to mental health and distress, the collective efforts of service user/survivor and women’s groups can be seen to constitute social movements in mental health. In this section I outline the organising of the two movements in turn, and then briefly consider the historical intersections between their organising, by way of introduction to the study.

Mental health service user/survivor groups

There are a variety of user/survivor groups in the mental health sphere, some independent and some instigated by service-led ‘user involvement’ initiatives. The independent groups constitute the ‘user/survivor movement’, although in practice there is considerable overlap between groups of different status. The present day U.K. movement began in the early 1970s and constitutes political organising among those with (often negative) experiences of being a psychiatric patient or user of mental health services (Rogers and Pilgrim, 1991; Campbell, 1999; Crossley, 1999). Its politics centre around resistance to, and overcoming of, oppression and marginalisation for mental health service users, and “a challenge to the perceived status of the diagnosed

mentally ill in society” (Campbell, 1999: 195). Although encompassing a range of ideological viewpoints (Wallcraft, 2003), user/survivor action is characterised by a resistance to the medicalisation of distress (Campbell, 1999) and preference for service responses closer to lay ways of relating (e.g. ‘talking treatments’) (Pilgrim and Rogers, 1997: 38, 43). Holistic understandings and a recovery paradigm are often advocated (Wallcraft, 2003).

The external aims of the user/survivor movement are both ideological and practical: it has sought to transform mental health service provision; to enhance civil or ‘citizenship’ rights and status for users/survivors (for example with respect to legal compulsion within services, employment practices and social security benefits); and to influence societal conceptions of madness and distress, and of those experiencing distress (Campbell, 1999, 2001, 2006; Barnes and Bowl, 2001; Wallcraft, 2003). These aims have been pursued through a variety of political strategies, including campaigning (Beresford, 2005) and the development of self-help alternatives to psychiatry (Lindow, 1994, 1995, 1999). However, the predominant strategy has been pragmatism and collaboration with mainstream mental health services (Lindow, 1995; Peck and Barker, 1997; Campbell, 1999, 2001; Barnes and Bowl, 2001), especially since the 1990’s as a result of ‘user involvement’ (Crossley, 2006).

The external impact of user/survivor action has been variable across localities, with alternatives to mainstream services being developed in some areas, sometimes with statutory sector support (Lindow, 1994, 1995, 1999; Peck and Barker, 1997). In terms of wider impact, the shift to user involvement which the movement helped bring about is generally recognised as a culture change within services (Campbell, 2001, 2006).

This has not, however, been accompanied by transformation of power structures (Campbell, 2006). As such, many of the core problems around which the movement has organised, such as the dominance of medicalised and chemical approaches to ‘treatment’, remain (Beresford, 2005). Furthermore, the introduction of new compulsory powers within mental health services has been a blow for the movement, whilst its impact on professional bodies and the public imagination has been described as limited (Beresford *et al.*, 2002; Campbell, 1999, 2001, 2006). Consequently, the movement is currently coming to re-define its politics and strategies, and its links with other political movements (Beresford, 2005; Beresford and Campbell, 2004; Beresford *et al.*, 2002; Campbell, 1999, 2006; Wallcraft, 2003).

Women’s groups and organisations

Women’s community and voluntary sector groups and organisations grew out of the second wave of feminism in the 1960s and to date number around 32,083 in the U.K. (Women’s Resource Centre [WRC], 2006). Organised around the social consequences for women of a disadvantaged position in society, most notably violence and abuse, they have been centrally concerned with ‘mental health’ but not always thematised as such (WRC, 2007). In part due to the failure of statutory mental health services to meet women’s needs (Payne, 1998), a key element of women’s action has been the development of separatist women’s ‘mental health’ services.² These have been informed by understandings of the social underpinnings of women’s distress as a framework within which individual women can give voice to their personal experiences and emotions (Williams, 2005) and identify their own needs (Payne, 1998). They encompass feminist therapy and counselling services; women’s day, community development and crisis centres; and Rape Crisis services and women’s refuges arising

from the Women's Aid Movement (Payne, 1998; Bondi and Burman, 2001; WRC, 2007). In addition, a number of women's mental health support groups and networks have emerged (for example, see Fenner, 1999).

Women service practitioners and users have often organised together - for example, to produce the Good Practices in Mental Health information pack about mental health services for women in the UK (GPMH, 1994); to provide mutual support and alternatives to mainstream services (Fenner, 1999; Lindow, 1999); in community development projects (e.g. Holland, 1995); and in campaigning groups to address issues affecting women within services such as violence (Copperman, 2004). Women service users have also organised separately, as part of the wider user/survivor movement (Crossley, 2006) as well as alongside men within the movement (Sayce, 1996; Barnes and Bowl, 2001). There has, in addition, been diversity in all forms of organising among women, with local women's mental health projects developing to address the different needs of black women, lesbians, working class women and other groups (Sayce, 1996; Fenner, 1999).

As for the user/survivor movement, the women's movement has provided considerable internal benefits for members in terms of developing empowering and liberating understandings and forms of help (Lindow, 1999; Barnes and Bowl, 2001). Yet feminist³ organising in the mental health sphere has arguably achieved more external influence due to its sustained action and political critique over a long history of struggle, along with its strategy of developing alternative provision for women. A separatist stance has meant women's services remaining marginalised in the voluntary sector (Mullender and Hague, 2005). However, apart from providing a valuable resource for

women, this has meant these ultimately serving to exert pressure for change in other service sectors by providing models of ‘good practice’ (Croft and Beresford, 1992; Barnes and Bowl, 2001). Most recently, this has taken place through the *Women’s Mental Health Strategy*, which has encompassed women’s voluntary sector services being looked to for statutory service commissioning (DoH, 2002, 2003b, 2006).

Working together for change?

As noted above, the organising of the user/survivor and women’s movements has often intersected (Barnes and Maple, 1996; Lindow, 1999; Barnes and Bowl, 2001; Crossley, 2006). Indeed, the emergence and development of the user/survivor movement was influenced by the women’s movement, as well as the trade union and U.S. Black civil rights movements (Lindow, 1994; Crossley, 2006). However, distance between the two has been maintained in part due to different origins: whilst the user/survivor movement grew out of opposition to aspects of mental health service provision, women’s activism did so as a reaction to the social conditions which affect women’s lives, with women’s services growing up afresh (Mullender and Hague, 2005). The escalating drive towards user involvement in services from the 1990s facilitated a movement of user/survivor action away from its original class-based politics and its links with other movements, including the women’s movement (Crossley, 2006). Furthermore, there have been points of departure, tension and opposition with elements of feminist organising.

In this paper, I examine these tensions in light of the new overarching mental health and human rights agenda outlined above and with a view to potential for (re)building political coalitions. I do so within a context in which the U.K. user/survivor movement has recently emphasised the need to form closer links with disability rights, anti-

poverty and Black and ethnic groups (Campbell, 2001; Beresford, 2005), but has tended to overlook its relationship with the women's movement. My aims are to: examine why issues of gender and links with feminist activism have tended to be overlooked in recent user/survivor action; explore the points of convergence as well as divergence and conflict between user/survivor and feminist politics and groups in the mental health sphere; and draw out implications for future political strategies. Since, in contrast to the relationship between the disability rights movement [DRM] and feminism (e.g. Morris, 1996; Hughes *et al.*, 2005), this area has not been widely developed, the paper takes a broad approach, demonstrating points firstly around the theme of ideologies and then identities. A brief description of the study upon which the analyses are based is provided first.

The Study

The paper draws on a localised, qualitative study conducted in the north-east of Scotland. It involved three mental health service user/community groups, sampled purposively according to their institutional affiliation and status: a statutory sector group attached to a local psychiatric hospital; a voluntary sector community group (members of which included service practitioners and providers as well as users); and an independent mutual support group. The main purpose of the first group was to provide information about mental health services and activities in the locality, whilst the second group took a stronger lobbying function with respect to mental health policy and services, and the third was primarily a support group but also made attempts to influence local mental health service provision at times. In keeping with the wider user/survivor movement, there was very little overlap between these groups and women's groups and feminist activism in the locality, which in fact had a history of

very progressive action on women's health and women's equality policies within the local council.

The overall aim of the research was to explore the actions of user/community mental health groups in the locality and their influence on services. Accordingly, it was centrally concerned with the operation of power. Since it was considered an under-explored area, and due to my own political commitments, it had a particular focus on gender and was conducted from a feminist perspective. The groups were openly approached about this focus, which was negotiated as fieldwork developed (see Lewis, 2007). The study was collaborative, 'interactive' and action-oriented in approach (cf. Kelly *et al.*, 1994) and employed multiple research methods, including: participant observation at group meetings; interviews and informal interactions with service users (female, n=9; male, n=16), practitioners (n=2) and providers/policy-makers (n=3); and analysis of local and national government mental health policy documents.⁴ All interviews were recorded and transcribed, and data was analysed both thematically and from a critical discourse perspective, concerning the relationship between language and power (Fairclough, 1992).

Although, as I go on to demonstrate, an interest in gender fell outside the immediate concerns of the participating groups, many members explored its relevance with me during reciprocal research exchanges (especially during follow-up encounters; see Lewis, 2007). However, one participant refused to be interviewed on these grounds, and in relationships with most (especially the men), inevitable tensions about our political alignments remained. In the analyses which follow, therefore, participants' reactions to me as a feminist researcher are as revealing of the ideological and identity

issues with which this paper is concerned as were the actual relations between user/survivor and feminist groups in the locale.

Ideologies

As indicated earlier, the philosophies and aims of the user/survivor and women's movements have overlapped. Both advocate shifting the ideological base of mental health services away from medicalised perspectives and practices and towards holistic, person-centred ones grounded in an understanding of wider social and political relations. Both also advocate moving away from traditional power relationships along with self-help alternatives to professionalism (Rogers and Pilgrim, 1991; Lindow, 1994). Yet there have also been important points of divergence and conflict between the ideologies of user/survivor and women's groups. In this section, I present findings from the above-outlined study in order to discuss two of these which are central to the mental health and human rights agenda previously discussed: understandings of mental health and distress, and violence.

Understandings of mental health and distress

When it came to understandings of and approaches to mental health and distress, the limiting ideological and political effects of asserting a primary identity as a user or survivor of mental health services were evident from the study. There were demands from the groups for more 'socially-oriented' statutory mental health service provision, such as "talking therapies" and community drop-ins offering alternative therapies. However, these still tended to be based on individualised and medicalised conceptions of distress, with only implicit reference to social perspectives (cf. Beresford, 2002). For example, group members still used the terms 'mental illness' or 'mental health

problems' invested in dominant bio-medical or psychological ideology. Moreover, during interviews, many participants engaged in critiques of medical dominance whilst operating within a medical framework and discourse, for example describing feeling very disempowered during interactions with psychiatrists whilst referring to oneself as having "manic depression". Furthermore, there remained differences of standpoint between those who accepted bio-medical understandings of 'mental illness' and those who were more ambivalent about these. The study thus demonstrated the difficulty of mounting a critique of the dominance of the 'medical model' whilst identifying and operating within its terms, and whilst the organising of the user and community groups at times tried to challenge the dominance of medicalised conceptions and responses, it simultaneously reinforced these.

These findings mirror those of other studies into user groups in mental health. The user/survivor movement's definition in relation to mental health services has been noted as impeding its success in managing to transcend medical discourse (Rogers and Pilgrim, 1991). Rather than being organised around a consensual 'social model' akin to that of the DRM, it "has tended instead to accept implicitly a medicalised individual model of 'mental illness', relying on a range of euphemisms like 'mental health issues' and 'mental health problems' to try and distance itself from the illness construct" (Beresford *et al.*, 2002: 393). In addition, other strands of organising mean that acceptance or otherwise of a medical model – with respect to understandings of distress and its 'treatment' - remains an area of contention within the movement (Wallcraft, 2003).

The research also indicated how the identity of the user/survivor movement has led to a priority on the influencing of mental health policy, services and legislation over wider civil rights and social inequalities issues (Campbell, 1999; Beresford *et al.*, 2002). There was a great deal of concern within the groups with influencing elements of existing service provision, for example through the re-establishment of a Patients' Council in the local psychiatric hospital, and although this particular campaign was unsuccessful, it was evident that such organising initiatives have been important for user groups in securing pragmatic gains (Lindow, 1995; Campbell, 1999). Yet it was apparent as well that this focus served not only to reinforce and help perpetuate current services, but also, as the following interview excerpt demonstrates, to occlude a wider social inequalities perspective:

R: I mean those [social inequality] things are almost sort of subsumed into the greater issues and it's almost, I mean, I think you know, maybe when, once the greater issues are dealt with I would imagine that sort of thing would start coming up.

I: Right, and the greater issues being?

R: User involvement in decision-making and in their own treatment.

(Discussion with Carol)⁵

Consequently, gender wasn't really discussed in the groups and in fact was even less so than other social inequalities such as ethnicity and social class. And this tied to a distance between the user groups and the local women's sector, with which the women participants were not involved. The study thus illustrated how user group organising around service reform can work to limit consideration of broader socio-political

relations surrounding mental health and mental health services, particularly gender, as well as links with other social movements (Forbes and Sashidharan, 1997).

In contrast, feminist organising around gender and other social-structural dimensions of power immediately constitutes a social model of mental health, a basis which has been used to establish new services as a priority as well as for engaging in other forms of political action. Through a conception of distress as a shared experience for women on a continuum (cf. Tew, 2005), this social model has also been important in enabling alignments between service users and practitioners. Conversely, as in this study, the ideological and political standpoints of user groups can produce a ‘them and us’ attitude towards mental health professionals, as well as some fragmentation among users (Rogers and Pilgrim, 1991).

Violence

The association of mental health service users with violence, and resulting increased compulsion, as well as stigma and victimisation for users, has been a key concern for the user/survivor movement. It has sought to challenge such perceptions, and to down-play this as an issue, pointing out that the association is largely unsubstantiated and has been fuelled by media reports (Beresford, *et al.*, 2002). By contrast, feminist perspectives have sought to expose and gender violence, including in the context of mental health services (Copperman, 2004; Williams, 2005; WRC, 2007). A tension therefore remains, and whilst in this study, the former concern was present for group members, especially the men, the latter was discussed by some of the women, one of whom described terrible experiences of violence within services (cf. Lindow, 1995). Furthermore, there was a silence around the issue within the semi-public arenas of

group meetings, and my attempts to break this during interviews were not always embraced by male participants, with responses often serving to negate my feminist concerns:

I: I mean there are a lot of gender issues in there aren't there? I mean a lot of the concern about violence and dangerousness is really about male patients as opposed to female.

R: Yeah but it's not male patients on female patients, ... you can be talking very minor property damage that causes you to be involuntarily held in hospital for six months. (Discussion with Steve)

It was evident, then, that this very real problem is a key tension between user/survivor and feminist perspectives with respect to the central concern within the former over compulsory detainment in hospital. The numbers of men, compared to women, being held in psychiatric hospitals in Britain have increased in recent years (Prior and Hayes, 2001), and this can partly be attributed to public concerns about 'dangerousness' (Beresford *et al.*, 2002). In some respects, this policy move can be considered to be in alignment with feminist calls for action on perpetrators or potential perpetrators of violence – whether or not the issue is framed in gender terms. However, it is an ever-growing area of concern for the user/survivor movement.

A related issue is that of sexual harassment/abuse and women only spaces. The frequent histories of abuse from men among women experiencing distress mean that 'women's spaces' have been key to women's initiatives and service responses within the voluntary sector (WRC, 2007). However, this study demonstrated how such

women-only spaces can be opposed by male members of user groups and cause considerable conflict:

I used to attend a drop-in, ... and they wanted to start a women's group. Fine, great, ... [but] it escalated, and we actually nearly demonstrated, to the whole facility being closed to men for a whole day, so... we got really angry about this ... And they tried to make it right by saying, 'well you men can have your men's only group'; we said, 'we don't want that'. Because that's another issue, [for] anyone with mental illness, the lack of relationships ... and any sort of seclusion; we wanted it to be as normal as possible, men and women mixed... (John)

As this quotation illustrates, the needs and demands of women, compared to men, as users of mental health services are not always compatible. There can at times be a lack of understanding on the part of men using services of why women may desire their own space, with the creation of women's spaces within mixed facilities sometimes leaving men feeling they are 'missing out' (Barnes *et al.*, 1996, cited in Barnes and Bowl, 2001). And these differing needs and demands mean there can be competition for resources between feminist and user/survivor groups and organisations (Crossley, 2006). In this study, this also included conflict and competition between one of the user groups and a 'feminist-oriented' day centre which ran women's groups. The success of the latter group in securing competitive funding contributed towards resentment from some members of the user group, who were highly critical of other local voluntary sector groups' practices of "feathering their own nests", as it was often put.

Identities

In addition to ideological consequences, the definition of the user/survivor movement in relation to mental health services has raised important identity issues for the movement and its relationship to women's groups. In this section, I again draw on the research outlined in order to explore three of these: negotiating stigmatised identities; negotiating multiple identities; and identities and internal politics.

Negotiating stigmatised identities

Organising around an identity and experiences as a user of mental health services was a point of conflict for many group members. This was because whilst they sought to critique the pathologising effects and reductionism, as well as social exclusion, associated with the positioning, their strategic alignment simultaneously reinforced such social perceptions and practices. One of the main, oft-cited (Lindow, 1995; Rogers and Pilgrim, 1996: 167) problems was the ways in which the association of a 'service user' identity with mental illness/madness undermined their authority and credibility, often referred to in terms of the difficulty of being "taken seriously". Participants noted as well the difficulty of operating within the field of mental health services but outside of identities which defined people in relation to these, along with the impossibility of ideologically de-investing the 'service user' identity.

These problematic social and political effects have meant for a questioning from feminist perspectives of the benefits for women of organising around a stigmatised identity which fails to centre the social inequalities and abuses which adversely affect women's mental health, or the gendered nature of power relations and ideologies in the mental health sphere (Forbes and Sashidrahan, 1997). From this research, however, it was also evident that the stigma attached to feminist politics and organising can be off-

putting for members of mental health groups. As a voluntary sector manager noted, this can be an obstacle to collaboration with feminist groups, especially when these become associated with lesbian identities:

We had a group which met in [mental health day centre] for a couple of years and then we thought wouldn't it be great to try to do this at the Women's Centre and that worked for a while, but it really then lost its kind of appeal to people, particularly when there was lots of lesbian stuff, posters and imagery around and people were really quite concerned about that, and said, 'oh you know, my chum said if I go to the Women's Centre I must be gay' and all this, so people felt they didn't want to use that any more, so we then had the group again at [day centre].
(Joyce)

The study therefore demonstrated how the central concern with the management of identities and labels for users of mental health services can be significant barriers to collaboration between mental health and feminist organisations. This seemed additionally so for the men, who were less likely than the women to speak during meetings and interviews about personal experiences of service usage, instead conferring authority through their (active) experience of working in the mental health field. Appearing to belie a desire to avoid the feminising effects of being positioned as a passive service user, and although not necessarily a conscious decision for participants in this study, this did suggest another motivation for men user group members to distance themselves from feminist politics – the danger of further 'feminisation' and concomitant increased difficulty in being 'taken seriously'.⁶

Negotiating multiple identities

As discussed earlier, mobilisation in relation to mental health has taken place from diverse standpoints. Yet this research evidenced how, within generic user groups, the ‘strategic essentialism’ (Spivak, 1987) of organising around an identity as a user of mental health services can lead to a reluctance to recognise and engage with matters of social difference and inequality due this being considered divisive (cf. Barnes and Wistow, 1991). The following comment, which came during a discussion of gender, shows the ways in which this can be compounded by problems of instability and inconsistency of organising:

Because you have this revolving door syndrome, people become ill again and again and again, it’s difficult *enough* to get enough service users to attend things, so there’s maybe sort of subconsciously I suppose, a feeling that if we start looking at like um, minor interest issues, it’s going to start fragmenting and it’s already difficult enough to get people together. (Carol)

As another participant pointed out, it was in fact political disillusionment at involvement with statutory services, meaning “you go on [to a committee] for six months and then give up on them”, as well as the debilitating effects of distress (among other factors) which produced this ‘revolving door syndrome’. In addition, alignment with ‘illness categories’ contributed towards fragmentation in organising. Particularly intriguing from this participant’s account, though, is her reference to gender as a “minor interest issue” and the overlooking of this as “subconscious”. These observations suggest how these concerns with fragmentation and consistency can contribute to a negation of and even silence around gender and other social inequalities within user groups. As illustrated earlier, there was an expectation that matters such as gender will be considered ‘later’, after more ‘fundamental’ concerns had been dealt

with, and even, as another female participant put it, that such considerations were “irrelevant”. Tellingly, other dimensions of social difference and inequality – most notably ethnicity – were more openly discussed, and this seemed partly due to the taken-for-grantedness of gender, which became eclipsed by the ‘service user’ identity. And again these issues tied to a distancing between user/survivor and feminist organising in the locality, which remained largely separate.

Identities and internal politics

These identity issues, and the associated silence around and negation of gender, allowed for the replication of traditional exclusions and gender relations within the groups (cf. Croft and Beresford, 1992). It was the men who generally held ‘user representative’ positions and who tended to speak longest and loudest at meetings. Furthermore, as two female service user interviewees commented when asked about women’s and men’s participation in meetings, it was generally men who chaired these, going on to justify this on the grounds that women probably “don’t put themselves forward” or were “not ready” for such a leadership role. And as one women noted, this can both reflect and construct gender hierarchies since “the more often you get the same people taking the chair, the more the idea is built up ... ‘oh he’s the chairperson, he’s up there’”.

According with the findings of Barnes *et al.* (1996, cited in Barnes and Bowl, 2001) in which such gender dynamics were explained by a female service user as arising from a “power vacuum” created by attempts towards non-hierarchical working, they were explained by several of the men users in this study as arising from a desire for status and reward. They also seemed related to the recent policy emphasis on ‘severe and

enduring mental illness', an umbrella category in which male service users tend to be over-represented (Busfield, 1999) and which became mirrored by some users' perceptions of who was a legitimate 'service user' participant in mental health politics. Yet they were also clearly permitted by liberal assumptions about gender equality within the user/community groups; women were involved and their presence served an 'alibi action' (Wodak, 2005), meaning that, both with respect to the power dynamics of the groups and their issues of concern, it appeared that matters of gender had been 'dealt with'. And once more this was in contrast to matters of 'race' and ethnicity, as well as social class at times, which did surface on occasion vis-a-vis user 'representation', in the former case due to the lack of black and minority ethnic members within the groups, which meant this dimension of inequality was also less of a threat to the current balance of power within these.

The insidious and poorly understood nature of gender inequalities were also implicated in other ways. There were less women than men service users at the meetings of the user and community groups, and most of the senior psychiatrists and statutory sector service providers the groups sought to influence were men. Yet there were perceptions among group members that men are under-represented when it comes to health and community groups and of 'female dominance' within the mental health system which somehow needed to be balanced out by the actions of user groups:

To be honest, my own observation is that it's generally more women on the committees and things because ... most people involved in mental health care, professionals I'm talking about, are women. So think it through, if anything, ... generally the services I would say, are biased towards women. (John)

These effects were reinforced by perceptions of male disadvantage within the mental health system as a whole and meant there could be a danger of male domination at an ideological level within mental health services taking over the agendas of the groups (cf. Wallcraft, 2003). The findings are similar to those of Parkes (2002), who reports how whilst from her study it was evident that women were very active and often held central positions within the user/survivor movement, many of the women members she interviewed reported “a very male bias in the user movement as a whole”, with one participant describing this “as one of the most pressing problems the user movement has to deal with ... because it’s not being openly acknowledged and recognised” (216).

Implications for future strategies

The formation of the EHRC presents an important opportunity for uniting various strands of work in mental health. Political changes leading up to this development were noted to provide opportunities for the user/survivor movement to broaden its agenda away from initiatives with mental health workers to “partnerships with people with physical disabilities, Black and ethnic minority groups and the poor” (Campbell, 2001: 88; Beresford, 2005). Clearly, however, it also provides a chance for user/survivor and women’s organisations, as social movements in mental health, to work together for change within an overall equalities and human rights framework. This research has demonstrated how this will require the working through of certain ideological and identity issues, and in conclusion, I outline four implications it raises for realising this new mental health and human rights agenda.

Firstly, and as the EHRC work on mental health is set to be within a social model approach (Diamond, 2007; D.R.C., 2007), I would suggest this provides the key to

overcoming many of the obstacles to coalition outlined earlier. Indeed, developing a consensual *social model of distress* has been highlighted as a priority for the user/survivor movement (e.g. Campbell, 1999; Beresford, 2002). As Beresford (2005: 48) notes: “What is needed is a framework for understanding that goes beyond acceptance of the existing ‘mental illness’ model, but which instead is based on a systematic critiquing of it – in the same way that the social model of disability has done with traditional individual models of disability”. Ideas being discussed to date encompass consideration of social inequalities and how abuses of power and experiences of powerlessness often serve to underpin distress, within a ‘normalisation’ framework (SPN, 2003; Tew, 2005). It would seem important in formulating this model, however, that the user/survivor movement looks not only to the DRM but also to feminist understandings and action. Women’s organising has been underpinned by an effective ideology critique of medicalised and individualised perspectives on distress (see, for example, Williams, 2005). This can be drawn on to inform social approaches to improving mental health and providing more helpful and empowering services for women and men, whilst helping ensure considerations of gender do not become marginalised or overlooked.

Secondly, the *medicalisation of violence* provides a related area for action, and again one which is key to the current mental health and human rights agenda. The stances of the user/survivor and women’s movements on violence are set apart by differential foci – on combating perceptions of violent mental health service users compared to emphasising violence as a gendered social problem affecting women. However, recent challenges from the user/survivor movement to the medicalisation of violence (Beresford, 2005) provide an important area of commonality with women’s organising:

recognition that it is unequal relations of power, including those of gender, rather than having a 'mental illness' that can explain violence in our society.

A third, related issue is *combating stigma and de-authorisation*. This research showed how perceived stigma of the other group can be an obstacle to collective action between women's and mental health user groups and how user/survivor organising can create divides between users/survivors and mental health workers. However, I would argue that within the current political milieu, and if tied to the political and ideological realignment above, recognition of the commonalities with women's organisations can help combat the stigma and deauthorisation experienced by user/survivor organisations. This approach could help create organic connections and understandings between user/survivor and feminist groups (Forbes and Sashidrahan, 1997) and thereby help strengthen the political position of both (cf. Mullender and Hague, 2005). Furthermore, it would aid coalition-building with those in positions of more power, which, although a point of ambivalence to date (Wallcraft, 2003), appears crucial to the future success of the user/survivor movement (Rogers and Pilgrim, 1991).

A last challenge for all those working within the mental health and human rights agenda is *recognising common and differentiated identities and experience*. This research suggests that this agenda needs to be informed by a perspective that can recognise that whilst experiences of distress and service usage can have commonalities, these are informed by social locations and power relations (as well as being unique to individuals) (Tew, 2005). The user/survivor movement has recently begun to address these issues with the formation of Black user groups (Shaping Our Lives, 2003; Wallcraft, 2003) and concern with black and minority ethnic issues (Shaping Our

Lives, 2005). In the aftermath of user involvement, though, it seems there is a need for a return to organising at the interface of mental health politics and that of a variety of social inequalities issues, including gender, class, and 'race' (Beresford, 2002; Crossley, 2006). In this manner, political action can help break, rather than perpetuate, the pervasive silence around gender within the mental health service milieu, and thereby help challenge gender inequalities.

In conclusion, with the current mental health and human rights agenda in the UK, it is a crucial time to be challenging dominant medicalised paradigms and power structures in the mental health field and to promote development of alternative, more empowering understandings and forms of help. It is a chance to strengthen work to date conducted by the user/survivor and women's movements and to bring this work together as a force for change. Through identifying a common philosophy and aims, identity issues can be negotiated and connections between the two movements, as well as others, can be facilitated. Indeed, this strategy, which widens the social base for action and means social movements in mental health can draw strength from the wider political context, can help facilitate connections between and further the efforts of all those working for transformation in the mental health sphere.

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Notes

¹ The dual term 'user/survivor' is used here since whilst 'user' signifies a broadly reformist stance in relation to mental health services, 'survivor' does so a more radical one, being used to denote survival of both distress and service usage, and to connote a positive identity associated with resilience and the overcoming of adversity.

² A report by the WRC (2007) found that 11% of women's organisations specialise in health or 'mental health' issues, 32% are concerned with violence or abuse towards women and 9% are 'support groups'.

³ 'Feminist' refers here to the concerns of the 'women's movement': women's interests and gender relations.

⁴ Ethical permissions were gained from Grampian Research Ethics Committee.

⁵ Interviewees have been given pseudonyms. Unless otherwise indicated, quotations are from service users. Transcribing conventions: 'R' stands for 'respondent' and 'I' for interviewer; ... indicates missing text; square brackets indicate added text, or text replaced for the purposes of anonymity.

⁶ Thanks to Professor Linda McKie and Professor Nickie Charles for these points.

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