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Exploitation of people with mental health problems: A critical discourse analysis of the role of mental health service policy in Scotland

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Abstract

This thesis engages with the phenomenon of abuse and exploitation of people with a diagnosis or experience of mental health problems. The thesis focuses especially on exploitation that does not meet legal thresholds of criminality. In this thesis, this type of exploitation is called “noncriminal exploitation”. The research project was designed to answer the research questions: RQ1) How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental health problems? RQ2) How are mental health service providers represented in this relationship? RQ3) What are the obligations – moral or otherwise - of mental health service providers in addressing noncriminal exploitation of people with mental health problems? RQ4) Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation?

To answer these questions, Foucauldian influenced critical discourse analysis is applied as a theoretical orientation and methodological framework to examine the policies that shape mental health services and practice in Scotland; and the potential effects of these texts on the lives of people who use those services, especially as it relates to exploitation of people who have mental health problems. The actual and potential roles of mental health services in preventing and addressing exploitation are examined.

An archive of policy and related documents relevant to mental health services in Scotland was selected; 10 representative documents from this archive were analysed for discursive themes, especially related to exploitation. A focused analysis of the current Mental Health Strategy of Scotland was conducted, to examine it both for internal discursive themes and for the presence of broader themes which emerged from the archive.

Competing discursive narratives embedded within the archive were discovered: Discourses that can be described as emancipatory and empowering of people with mental health problems (Rights-Autonomy

discourses) are countered by discourses that embody paternalistic attitudes, medicalization, and stigma (Harms-Paternalist discourses). This thesis critically examines sample texts for the presence and effects of these discourses; traces the discourses throughout the Scottish Mental Health Strategy and discusses potential effects of these discourses.

When assessed by the stated goals of the Strategy and related policies, these discourses impede progress towards development of services that are person-centred and rights-based. This reinforces the marginalization of people with mental health problems and can impede progress towards the explicitly stated goals of the Strategy.

The thesis discusses the impact of these discursive realities on the issue of non-criminal exploitation. Roles and obligations of mental health workers encountering exploitation are explored. Policy solutions, as well as actions aimed at mitigating Harms-Paternalist Discourses, are proposed.

Lay Summary

This thesis explores the policies and professional guidelines that shape mental health service provision in Scotland, with the purpose of illuminating issues surrounding the exploitation of people with mental health problems. Of special interest are forms of exploitation that do not meet the criteria for being criminal. The aim of this research was to gain insight into how mental health policy is structured to protect people with mental health problems from abuse and exploitation, and potential opportunities to design policy that provides such protection. This thesis centres on the idea that the use of language in these policies can be examined to provide these sorts of insights.

To achieve this, documents representing the policy of mental health services, and representing the practice guidelines for people who work in the field of mental health were examined. It was found that while the Scottish Government has described a goal of changing mental health services so they are person-centred and human-rights based, policies and practice remain entrenched in paternalistic language and principles. It is concluded that these principles make it difficult to enact any meaningful interventions for people with mental health problems. In short, people with mental health problems – especially those with a diagnosis of a chronic mental illness – play dual roles in mental health services: On one hand they are treated as potentially dangerous and vulnerable, but on the other hand are given autonomy to engage in risk-taking behaviours that might lead to harm. The tension between these two roles will prevent development of effective policy to help protect people from noncriminal exploitation. It will also impede effective transition to person centred and human rights based mental health services in Scotland.

In this thesis, several recommendations based on this finding are presented. These recommendations especially focus on the need to remove stigmatizing and marginalising language and principles from mental health service policy, starting with the Mental Health Strategy of Scotland.

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To my son, my pride and joy: Jasper. I love you infinity, and I dedicate this to you. Mama is finally done her grown up school, let’s play!

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Chapter 1 Introduction

This thesis uses Foucauldian influenced critical discourse analysis as a theoretical orientation and methodological framework to examine policies that shape mental health services in Scotland. It examines the effects of these texts on the lives of people who use mental health services, especially as it relates to remediation of abusive and exploitative circumstances experienced by people with mental health problems a diagnosis of mental illness. The central phenomenon that this thesis engages with is the issue of abuse and exploitation of people with mental health problems by members of their communities, with a specific interest in the subtle issues revealed by noncriminal exploitation. The thesis demonstrates how discourse reveals attitudes and positions taken towards individuals with mental health problems, which enable abuse and exploitation; and more importantly it seeks to critically examine the actual and potential roles of mental health services in preventing and addressing this form of abuse. This thesis concludes that the same discourses that reveal and enable exploitation of people with mental health problems are reflected within the policies of mental health services and the guidelines that influence professional practice in Scotland. Further, the thesis concludes that there is a fundamental conflict between these discourses and current movements towards developing person-centred and human rights-based mental health services.

Critical discourse analysis [CDA] was applied to identify conceptual assumptions embedded in mental health service policies and professional guidelines in Scotland, and to compare and contrast these concepts and effects with the stated goals of these same policies. An underlying assumption is that the texts examined are reflective of - and shape - discursive practices embedded in broader social contexts. Consistent with the use of CDA, this thesis is focused on “ways social power, abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context” and is “especially concerned with resisting social inequality” (van Dijk, 2001, p. 352). CDA is used here as both

a theoretical stance and a methodological approach. It is used to illuminate the way language is utilized in social, historical and political contexts, and it is used to critically examine the purposes and the effects the use of language has, especially those effects that are marginalizing or oppressive.

For the analysis, an archive of policy and related documents relevant to mental health services in Scotland was selected; 10 representative documents from this archive were analysed for discursive themes that can illuminate issues related to the experiences of people who use mental health services. Following this, a focused analysis of the current mental health strategy of Scotland was conducted, to examine it both for internal discursive themes as well as for the presence of the broader themes which emerged from the archive.

The conclusions of this analysis are that there are competing discourses embedded within the archive of policies and strategic documents that underlie health services provided to people with mental health problems. Discourses that can be described as emancipatory and empowering of people with mental health problems are countered by discourses that embody paternalistic attitudes, medicalization, and stigma. This results in a situation in which meaningful progress toward the development of person-centred and rights-based mental health services is hindered. This thesis critically examines sample texts for the presence and effects of discourses; uncovered two major discursive threads; traces these discourses throughout the Scottish Mental Health Strategy; discusses potential effects of these discourses; and suggests possible remediating actions.

1.1 Research Aims and Objectives

This study was initially designed with two broad aims, and was further developed and refined with other aims, described below.

The aims as initially conceived were to 1) describe and understand the social-historical forces that influence how people with mental health problems (or mental illness) are vulnerable to abuse and exploitation, and 2)

understand and describe the resources available to mental health service providers, and how the service providers may – or may not - utilize these resources effectively to provide support and assistance to people experiencing exploitative circumstances that are outside of the authority of the judicial system.

A concern with exploitative issues that lack a legal framework was initially the primary focus of this thesis. Namely, exploitation that does not reach the threshold of illegal activities. While there are similarities between criminal and non-criminal exploitation, people who are subject to criminal acts have a relatively clear path to seeking assistance. At the outset of this project, my concern became those exploitative circumstances that lacked such legal frameworks.

The objectives were to trace discourses through various levels of the mental health service system and broader social communications, analyse these discourses and their potential impacts on health services workers and the broader public's perceptions; and then to understand the resulting roles and identities of people with mental health problems in relation to the general public and (more specifically) in relation to mental health services.

Further, the initial study design aimed to examine the frameworks in which health services service providers may provide solutions to the problem of noncriminal exploitation of people with mental health problems. Thus, it was intended that the results of the first stage would inform concrete policy proposals for mental health services in Scotland. Scotland was chosen as a location for this study in large part due to the Scottish Government's explicitly stated commitment to embedding human rights principles in mental health services (Scottish Government, 2007). This was an appropriate fit, in that exploitation in any form is a clear violation of human rights (Harding & Salmon, 2008); thus, it would be expected that a rights-based framework is most able to address issues of exploitation.

The aims were revised during the process of data collection and the uncovering of evidence. The first stage of data collection and analysis (documentary analysis and tracing of discourses) revealed troubling gaps and inconsistencies between the major discourses that were related to the topic of exploitation. These gaps and inconsistencies led to the inescapable conclusion that regardless of what potential solutions were proposed for the "problem of exploitation", it was extremely likely that the solutions would not have any substantial impact. The inconsistencies in discourses revealed something of a fatal tension embedded within the principles that mental health services are built upon. This tension, or gap between principles, is in fact the very thing that would account for noncriminal exploitation to occur without room for intervention by mental health service workers. Within this gap in the system lies a fundamental flaw that provides insight into the lack of progress towards radical systemic change in mental health service delivery.

Thus, the revised aim of the study became to examine Scotland's current Mental Health Strategy, in the context of tracing these same discourses in the strategy. In this stage, the secondary aim was to examine potential problems and propose potential solutions at a strategic level. Finally, the study aimed to revisit the question of exploitation using the discourses uncovered in the analysis of the archive as a theoretical lens.

The thesis takes a grounding position that people with mental health problems have their own agency and individualized reasons for engaging in behaviours. This is inclusive of engaging in relationships that are exploitative. It is important to note that it is not my intent in this study to examine the behaviours or motivations of people who use mental health services. My focus is, intentionally, on the services themselves, and the discourses deployed and embedded within the texts, and the roles and structures they empower and enforce within society – including what roles they define and enforce on the persons who utilize those services.

1.2 Note on Terminology

This thesis primarily uses the term “mental health problems”. This is intended to both capture a wide range of issues that fall under generally accepted categorizations of issues or problems of mental health and mental illness. As is discussed in Chapter 2, categorizing issues of mental health and illness is fraught with challenges and controversy, and as such the use of this term is an attempt to reconcile the complexity of the set of issues, as well as an attempt to avoid stigmatizing language. That said, in places within this thesis, there is some nuance in distinctions that should not be lost. In those specific cases, terminology such as “mental illness” or “severe and enduring mental illness” is used. This is done for example in cases where it is not helpful to imply a broader array of ‘problems’ that don’t meet the threshold of a diagnosable illness. Further, it is used where a relationship with medical services or the medical model is implied. As such, where the phrase “mental illness” is used, it should be understood by the reader to be intentional and intending to evoke an understanding of the relationship with medical or health services. This is in contrast to the broader category of “mental health problems” which is not intended to imply specific relationships. This should also not be taken to imply that there is any true or meaningfully clear distinction between the two descriptors.

In this thesis, in referring specifically to “mental illnesses” I specifically refer to illnesses that are defined specifically within diagnostic manuals such as the Diagnostic and Statistical Manual V-TR (APA, 2013), or the World Health Organisation [WHO]’s International Classification of Diseases and Related Health Problems (ICD-10) (WHO, 2006). In these cases, the term “illness” will be retained, as illness best describes the specific issue that is addressed.

In the literature review (Chapter 2) specifically, the terms “mental illness”, “severe and enduring mental illness” or “mental disorders” will be retained where that is the language used by the literature in question, and where it seems appropriate to keep the original language in order to not obfuscate the authors’ original meanings.

1.3 Research Questions

As will be discussed in more detail in Chapter 3 (and based on the literature review), the research questions were chosen and adapted in order to address a gap in our understanding of the rights of people with mental health problems.

RQ1) How does the relationship between society and people with mental health problems affect or allow exploitation of people with mental health problems?

RQ2) How are mental health service providers represented in this relationship?

RQ3) What are the obligations – moral or otherwise - of mental health service providers in addressing exploitation of people with mental health problems?

RQ4) Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation?

1.4 Motivation for Study

This study was motivated by my personal professional experience employed in an acute care psychiatric unit in Canada, working with persons with mental illnesses in an acute phase. Many of these people were admitted under the mental health act. This experience revealed that people with mental health problems are frequently subject to exploitation in many forms. Further, it was evident, from a first-person practice, that in many of those circumstances, there was little that we – that is, the nursing, medical or allied staff (such as social workers) - could do to assist the individual with their circumstances. This professional experience positioned me in relation to the documentary archive and became foundational to my understanding of the discourses, as will be discussed in section 3.5.1. The remainder of this section, I describe my understanding of the issue that resulted in the conceptualization of the thesis. This understanding was formed due to my relationship with mental health services and the role I play within them.

In conceptualizing the thesis, I started from the following understandings: There is evidence in literature that supports the premise that persons with mental health problems are more likely to be exploited than persons without mental health problems (see for example Jain et al., 2017; Poreddi et al., 2019). However, this claim is poorly researched. Research that has occurred has largely been focused on forms of exploitation that are criminal and subject to mandatory reporting; namely, sexual or financial exploitation of children or older persons (Gali et al., 2019; Lichtenberg et al., 2013; Acharya 2014; Cannon et al., 2008; Kiss et al., 2015; Meyer et al., 2014). It does not often focus on how mental health problems create a *condition* of vulnerability to exploitation. Nor does it focus on forms of exploitation that exist below the threshold of criminal reportability, which were of special interest to me. As such, this study was also motivated by a desire to fill a gap in understanding the relationship between the presence of mental health problems and exploitation, especially to inform future health service policy.

The topic of exploitation is of special interest in large part due to its complexity. Exploitation is often described as a form of abuse, but there are characteristics of exploitation that differentiate it from other forms of abuse (Sample, 2003; Wertheimer, 1999). It is these characteristics that make it a particularly interesting case study that strains existing mental health practice and creates unique challenges for health services and health allied professionals, as well as for those who experience exploitation. “Exploitation” is poorly defined in literature and practice, and is a philosophically contentious topic (Wertheimer, 1999). This has made developing or enforcing policy in this area difficult (Wertheimer, 1992). This issue is described in detail in the Literature Review (Chapter 2).

This ambiguity does not absolve health service providers or policymakers from acting on a moral imperative to provide protections for vulnerable persons from exploitation that does not raise to the level of clearly reportable criminal activity. More pressingly, as will be discussed in Chapter 2, in the section on Human Rights, it does not absolve the obligation to mitigate the

vulnerability that exists in both society and embedded within the mental health care system. What is clear is that exploitation exists, it disproportionately affects people with mental health problems (either quantitatively or in terms of amplitude (Poreddi et al., 2013; Elbogen et al., 2011; Black et al., 2008; Kelly & McKenna, 1997).

As it stands, given the lack of literature or clear policy guidance, it is left to the individual practitioner to attempt to help (or not) based on their own professional judgment and knowledge of the factors in play. It is also left to individual knowledge of local resources that might be useful but are not clearly dedicated to this issue.

A rigorous definition that illuminates the moral wrong embedded in exploitation, as well as guidance for practitioners on how to protect the rights of persons with mental health problems, would be beneficial. It is this need that initially motivated this research. Further, a clear policy direction and resources for this issue would assist health care service providers or other caregivers in navigating this harmful but complex form of abuse.

1.5 Background & Summary

Social, historical, and political power fundamentally influence the lived experiences of people with mental health problems and diagnoses of mental illness. This thesis critically examines discourses to gain insights into how socio-historical and political power dynamics have influenced how and why people with mental health problems are vulnerable to exploitation in the context of the mental health strategies and policies of the government of Scotland and the health services and health allied professionals who operate within the mental health system of this country. It examines how and why this phenomenon is both inevitable and difficult to counter within the current state of policy and practice.

Medicalization of mental health services has placed the experiences of people with mental health problems under the scrutiny - and authority - of health services and health-allied professionals whose actions are authorized

and sanctioned by government (Dudley et al., 2012). Governments play a fundamental role in not only delivering mental health services but shaping mental health policy (Grob, 1994). Despite recent policy developments, especially those aimed at empowerment and emancipation of people with mental health problems (such as the recovery movement) (Smith-Merry et al., 2011), stigma and abuse of people with mental health problems are pervasive (Brohan et al.; 2010; Johnstone, 2016). The presence of stigma, similarly, can lead to individuals with mental health problems engaging in self-conscious behaviours aimed at looking “normal” to pre-empt stigma and discrimination (Whitley & Campbell, 2014). Stigma and discrimination are especially experienced by people who are less able to conceal or hide the characteristics of their illness or problems (Brohan, et al., 2010). People with a diagnosis of severe and enduring mental illness (for example, schizophrenia) thus will be more likely affected by stigma and internalized stigma (Whitley & Campbell, 2014).

Among the forms of abuse commonly faced by marginalized people, and thus people with mental health problems, is exploitation (Link & Phelan, 2014; Poreddi et al., 2013). Though the increased risk of exploitation of people with mental illness is acknowledged in literature (Kelly & McKenna, 1997; Poreddi et al., 2004; World Health Organization, 2010) exploitation of persons with mental health problems has received very little attention in terms of policy or even research. This is even more the case for forms of exploitation that do not reach the threshold of reportable criminal abuse. This issue is outlined in detail in Chapter 2 and further demonstrated in Chapter 4. The dearth of literature on the subject was one of the initial issues that raised interest in this topic.

This thesis project began with an examination of the nexus of issues underlying the exploitation of person with mental health problems, including how it is enabled within society, and how mental health service providers may or may not be equipped to assist persons experiencing non-criminal exploitation. This research used a critical discourse analysis framework

(Wodak & Meyer, 2009; Fairclough, 1995), to analyse documents (texts) underlying mental health services delivered under the guidance of the government of Scotland. This process and analysis is described in Chapter 4. The initial collation and examination of the archive related to health service services and exploitation revealed striking patterns within the discourses: Namely that there exist 2 major discourses competing within the archive. These intertextual (or “macro-discourses”) discourses are present in most if not all contemporary policy related documents. Both discourses come with extensive histories. The 2 discourses define distinct – and incompatible – roles for people with mental health problems in society and as patients in the mental health service system. These discourses I call the Rights-Autonomy Discourse and the Harms-Paternalist Discourse.

With this understanding of competing discourses embedded throughout the archive, the second stage of the data analysis was an undertaking of a critical analysis of Scotland’s Mental Health Strategy, a process described in Chapter 5. This analysis revealed the presence of both discourses, and thus embeds their dichotomy within the very fabric of mental health service policy in Scotland. Through critical analysis, it is determined that these competing discourses will continue to hinder true progress in the move toward rights based and person-centred mental health service in Scotland. This is illustrated by returning to the case study of exploitation. Through analysis of the current status as well as of potential policy solutions for this issue, it is revealed that the incompatibility of these discourses in fact allows for such problems to exist, and to remain unsolvable. A critical discussion of these tensions is described in Chapter 6.

Finally, this thesis revisits the issue of exploitation of people with mental health problems in Chapter 7. In this chapter, I explore the roles and obligations of mental health workers encountering exploitation. I explore the ways embedded Harms-Paternalist Discourses do (and will continue to) stymie attempts at proposing actionable policy solutions to this issue. Lastly, I

propose such policy solutions, as well as actions aimed at mitigating the Harms-Paternalist Discourses.

1.5.1 Exploitation and People with Mental Health Problems

The Scottish Government has explicitly centred its Strategy around a commitment to human rights (Scottish Government, 2017). Despite this strategic commitment aimed at protecting the human rights of people with mental health problems, stigma and abuse of persons living with mental health problems are pervasive (Elraz, 2018). Among the forms of abuse faced by this marginalized group is exploitation (World Health Organization, 2010; Poreddi et al., 2004; Kelly & McKenna, 1997). Exploitation involves taking advantage of existing power imbalances to unfairly extract something of value from another (Deveaux & Panitch, 2017; Wertheimer, 1996). Exploitation is a violation of the human dignity of a person (Sample, 2003), and can occur within individual relationships, or by institutions (Sample, 2003).

It is accepted in the literature that as exploitation is a violation of human rights, state institutions have a positive obligation towards protecting vulnerable people from exploitation (Wertheimer, 1992). People who experience mental health problems are generally acknowledged in the literature to be at increased risk of exploitation by others (Bonguli et al., 2013; Boysen & Isaacs, 2020; Jain et al., 2017; Killaspy et al., 2009; Poreddi et al., 2019) - though very few studies exploring the phenomenon as it affects people with mental health problems exist. That said, can be inferred from the various literature that mental health problems, and especially the stigma associated with mental health problems, creates a condition of marginality and vulnerability to exploitation (as will be explicated in Chapter 2).

Exploitation takes many forms, many of which are clearly illegal. This may include sexual exploitation, especially of minors, or financial exploitation, especially of older adults (Gali et al., 2019; Acharya, 2014; Lichtenberg et al., 2013; etc). But there are forms of abuse that meet *academic* definitions of

exploitation, but do not meet the criteria of *legal* definitions of exploitation (Sample, 2003). These forms of abuse can cause extraordinary harm but, as they are below the threshold of criminality, there are no legal or other state assigned protections for people who are exploited in this way.

It was my hypothesis, tested through this study, that these exploitations of people with mental health problems are enabled by a combination of stigmatizing attitudes towards people with mental health problems, and by a misapplication of discourses of empowerment. Per this hypothesis, this occurs throughout society, as well as in mental health service and allied institutions.

Among the few studies that have been published on the topic found that individuals living with mental health problems were regularly subjected to financial exploitation that took forms that are not necessarily illegal, such as: Being charged an unfair fee for services; being ‘encouraged’ to ‘share’ benefits money with friends, family, and acquaintances; lending money that ultimately go un-repaid (Kelly & McKenna, 1997). These conform directly to the forms of non-criminal exploitation witnessed in practice by this author (Pachkowski, 2016), such as: Being pressured to share limited financial resources with family members; being pressured to exchange sex for a safe place to live; being pressured to sell property privately and at well below market value; being ‘encouraged’ to buy services they do not need (Pachkowski, 2016). It is these types and forms of exploitation that were initially identified as the primary focus of this study. While the study was broadened to include other forms of exploitation, noncriminal exploitation remains an important concept that requires further investigation due to the invisible nature of this form of the abuse of rights of persons with mental health problems.

While not necessarily illegal, especially in cases where both parties are ostensibly consenting to the exchange, these instances do fulfil the definition of exploitation (Sample, 2003). In such cases as described, a clear harm is

being done, and most reasonable persons would agree that the actions of the more powerful party are morally wrong.

Given that persons with mental health problems generally meet many definitions of vulnerability - including some legal definitions (Williams, 2002) - there is a surprising lack of policies or laws designed to protect them from exploitation, such as exist for other vulnerable groups, such as older adults, children, or persons with intellectual disabilities. This lack of laws or policy that deals with such forms of exploitation means that service providers have no specific guidance on how to confront such situations (Pachkowski, 2016). There are no obvious guidelines for what actions should be taken by health service duty-holders when they have a client or patient who experiences exploitation, but it does not rise to the level of criminal abuse. There is also no shared language to identify and communicate concerns about this phenomenon.

1.5.2 The role of mental health service providers

There is an explicit and implicit moral imperative that health services providers, as duty-holders (Gooding, 2021) to vulnerable persons, protect to the extent of their abilities those persons from exploitation and abuse. These imperatives are discussed in further detail in Chapter 2. This is represented in legal powers imbued by the mental health act, legal obligations toward reporting abuses of vulnerable persons, and directives embedded within professional codes of ethics. On the other hand, there are no obvious guidelines for what actions should be taken by health services duty-holders when exploitation does not rise to the level of criminal abuse.

There is significant evidence that people with mental health problems are marginalized and stigmatized (as above). There is significant evidence that they, as a group, are more likely to be abused and exploited than people without mental health problems. There is also evidence that people with mental health problems are more likely to experience day to day abuses and exploitations that are more subtle and insidious than the criminal acts that

generally receive attention. Insights into this phenomenon are revealed through critical analysis of the discourses in the texts related to mental health service delivery.

1.5.3 Discourses in Mental Health Services

As previously stated, this study uses CDA to examine, identify and critically engage with discourses in key texts used in mental health services in Scotland, to gain insights.

As Fairclough (1995, p. 135) describes it, CDA is used

> *to systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power.*

Discourse, simply stated, is the use of language for communication (Gee, 2014a). Discourse analysis is applied to analyse and understand the language used to communicate ideas, as well as the effects it has. Through the “critical” element of CDA, imbalances in political and social power that emerge from the effects of discourses are highlighted (Blommaert & Bucean, 2000). Further, in using a Foucauldian inspired approach to CDA, researchers do not seek to remain neutral in analysis, but rather aim to directly challenge these power inequities and their harmful effects (Jäger & Maier, 2009). In this way, the research becomes inherently political.

The elements of discourses are not only the details of language – the specific words that are use, the elements of language and syntax – but also the pragmatic elements of the way that the language is used (Gee, 2014a; 2014b), and the context of the language (Fairclough, 1995). Language (choice of words, specific turns of phrase, etc) is used by people to accomplish goals. People construct narratives not only to accomplish something or communicate an idea, but also to influence the understanding

of their audience (Gee, 2014a, 2014b). The speaker and the listener co-create meanings, as well as bring their own meaning to an exchange (Gee, 2014a; 2014b). In this viewpoint, language forms social realities. In this theoretical orientation, language does not simply communicate the nature of reality: Fairclough (1995) describes language as “active”, in that it has a powerful role in constructing our shared, lived realities. Further, these realities are co-constructed (Gee, 2014a; 2014b) through language exchanges.

Gee’s (2014a; 2014b) description of the relationship between speaker and listener is important in understanding how different realities can be constructed within the same space, and in understanding the epistemological stance taken within this thesis (described in detail in Chapter 3). That is, the position taken that social realities are discursively constructed within relationships, and thus can be better understood through study of discourse. The relationship between speaker and listener, and the intentions and understandings that different speakers will bring to different audiences (and that frame how the messages are received by the audience) mean that each sphere of interaction will form a new set of social realities. This is important when we consider the different discourses that are present within - for example - communities of people with mental health problems, and the discourses that are present *between mental health services and people with mental health problems.* In each of these interactive spheres (within the community of people with mental health problems, and between people with mental health problems and mental health services, all within the context of a broader social, political, and historical context) there will be different discourses constructed – indeed, different social realities. Each of these social realities comes with its own set of rules, and individual actors will have different identities and different roles to play within that set of rules (Gibbs, 2015). Again, this describes in part the epistemological understanding at the heart of this thesis: That interactions between persons create the social realities in which people live, and mediate their experiences. The relational

nature of how these realities are constructed means that identities are dynamic and subject to change.

This thesis will focus on the discourses constructed at the intersection between mental health services and people with mental health problems. It is important to note that the thesis is fundamentally informed by the discourses that occur within the community of people with mental health problems, and the role of broader social discourses that shape and bend the relational discourses under study. As such, this thesis will also address these where it is appropriate or required to form a deeper understanding of the origins and contexts of various discursively constructed realities.

The processes of discourse form *identities* of and for people within a social, political, and historical context (Gee, 2014a; 2014b). Identities can be formed by people or groups for themselves, and they can be used by those in power to impose identities onto others. It is in this latter scenario that this study is particularly interested. This thesis therefore seeks to explicate not only to *describe* discourses which are embedded within the structures of mental health services, it seeks to critically engage with *the effects of* those discourses in terms of service user identities and experiences. The thesis engages with the phenomena of formulated social realities which dictate how users of mental health services interact with service providers. As was stated above, while this is the central phenomenon of interest, it is difficult to extricate these discursively constructed realities from their broader social, historical, or political contexts and as such these will be described as well.

An examination of the discourses in the documentary archive reveals that people with mental health problems are often portrayed (and thought of) as dangerous and as non-contributors (i.e. burdens) to society. This therefore describes a major component of the *given social identities* of people with mental health problems. These discourses are evident in policy-setting documents (such as the Mental Health Strategy), and especially in the Mental Health Act. One can also trace these discourses through diagnostic terminology – such as criteria that people reach the threshold of mental

illness when their symptoms “interfere with normal functioning” in employment, educational or social settings. These discourses are therefore pervasive throughout the policies and practices that govern mental health professionals. Particularly those policies that empower workers such as medical and community based mental health professionals to control or constrain the activities of people with mental health problems through coercive treatment and admissions. One way to look at this phenomenon is that these discourses are used to justify the removal of some rights of people with mental illnesses under some circumstances. To reiterate, those circumstances are often framed in reference to the individuals’ ability to function in relation to employment, education, and social settings.

However, one can also trace discourses that portray people with mental health problems as autonomous, fully contributing persons who are not dangerous and require no special considerations in law or policy – people with mental health problems are “the same” as other members of society per this discourse. These discourses also help to frame the social identities of people with mental health problems. These discourses emerge from a variety of movements that aimed to emancipate people with mental health problems from the effects of stigma, such as the consumer empowerment, recovery, and disability rights movements (discussed in Chapter 2). One of the outcomes of such movements is an emphasis on the human rights of people with mental health problems. Within these discursive themes, we see a construction of people with mental health problems as deserving of full autonomy and freedom of life choice. Within this thread of discourse, only in the most severe of cases – when mental health problems are deemed to impair the cognition and sound judgement of a person – should there be policies or practices that assist mental health workers to interfere with immediate rights. However, per this thread of discourse, these interventions are to be time limited and engaged only with the intent to protect or empower the rights of people with mental illness in the long run.

With that said, within the texts of these policies and procedures, the discourses within the policies and procedures tend to be ultimately restrictive rather than empowering. That is, even when the intent is to ultimately protect the rights or health of an individual with mental health problems, the actions dictated by policies and procedures are aimed at *limiting* freedoms and rights. For example, imposition of power of attorney or substitute decision making processes. In this way, we see the first discursive string (that of *danger/non-contributing*) is insidiously invading the second discursive string, within the policies and procedures of mental health services in Scotland.

1.5.4 Summary of Conclusions

The conclusion drawn in this thesis is that there are two competing discourses present within mental health policy and strategy documents: 1) discourses that discursively marginalize and control people with mental health problems and 2) discourses that emancipate and empower people with mental health problems. These discourses are incompatible. I argue that the nature and incompatibility of these discourses creates an ambiguous "grey zone" in which it is very difficult to enact policy that is effective in addressing the types of vulnerability illuminated by the problem of exploitation. In a more practical sense, the incompatibility between these two discourses impedes realistic progress towards developing and delivering person-centred and rights-based mental health services, a stated goal of the Scottish Government.

The first discourse I have named the *Harms-Paternalist Discourse*, to reflect the identity and place that people with severe and enduring mental health problems have within this constructed reality. The Harms-Paternalist Discourse maintains a commitment to the fundamental nature of mental illness (and mental health problems) is medical, and thus the primary treatment of mental illness is appropriately medical in nature. That is, the identify formed by the Harms-Paternalist Discourses is that people with mental illness are patients. It simultaneously preserves the notion that persons with mental illness are more likely to be dangerous, and to be non-

productive members to society - namely that they often are unemployed. The identity formed for people with mental illness are that they are lazy, and immoral and dangerous. They are given the role of “patient”, reinforcing notions that physicians and medical practitioners are the best placed to treat them. The identity of “dangerous” is emphasized by the primary role of law enforcement plays in mental health services. The origins of these discourses are, unsurprisingly, historical, and political, the dynamics of which have been described by Foucault himself (Foucault, 1965).

The second discourse I have named the *Rights-Autonomy Discourse*, to reflect the emphasis on the dignity, human rights, and agency that people with mental health problems have in this constructed reality. Within this discourse, people with mental health problems are equal holders of human rights, which should be respected at all times, even in moments of severe ill health. These rights can be provided by giving choices and careful consideration. People with mental health problems hold inherent dignity and have agency. This discourse shares many properties with, and possibly finds origins in, consumer-rights and similar movements.

The discourses are not compatible with one another in policy, and the presence of the first type of discourse impedes progress towards the protection of the rights of people with mental health problems, and especially those with diagnosed severe or enduring mental illness. I argue in this thesis that in fact, much of the subtle and insidious abuses and exploitation that I have described are facilitated by the existence of this tension that exists between discourses. Certainly, the tension hinders any attempts to construct a policy that could be pragmatically implemented under the current conditions, which would help mental health workers assist in a meaningful way non-criminal forms of exploitation they witness in the people who use services.

1.5.5 Recommendations

In Chapters 6 and 7, recommendations for mental health services in Scotland are put forth. First, in Chapter 6, broad recommendations are made with an eye toward improving mental health services such that they are better aligned with their own stated purposes. These recommendations include, as one might expect, meaningful engagement with stakeholders: However, it is highlighted that many previous attempts at stakeholder consultation have in fact very clearly identified many of the issues identified by this research. Thus, one conclusion of this thesis is that much of the vital knowledge required to transform mental health services in Scotland has already been shared with policy makers at the very top levels of government. The lack of uptake of this feedback by policy makers was a startling discovery, and revealing of potential power struggles that are consistent with competing values.

In Chapter 7 recommendations for action directed specifically at abuse and exploitation are put forward, informed by the data analysis. These recommendations are not intended to provide a comprehensive solution to the issue, but are presented, with contextual information, as potential concrete actions that are realistic in the current discursively created environment. These suggestions are: Media awareness and appropriate representation in media; clarification of legal protections and obligations of service providers; and government sponsorship of an advocacy organisation.

1.5.6 Significance

For individuals with mental health problems, for the population and for health services workers, it becomes a difficult task to adjudicate whether a person should be allowed to “make their own choices” (such as recommended by the British Medical Association, 2018) or if they should be offered formal assistance – especially when much of the assistance available to offer tends to be restrictive or may cause further harm. This conflict is in fact evident in the literature. There is evidence that workers are hesitant to intervene when their patients/clients are being abused or exploited for several reasons (Levi

& Portwood, 2011). One major reason is a lack of clarity about their actual obligations and rights, and another is a fear of causing more harm than good (Ahmed et al, 2016). People who deliver mental health services need more tools to deal with these issues when they arise. This is clearly a problem even when the abuse/exploitation of the client is clearly illegal, and is even more of an issue when the abuse/exploitation is borderline or not clearly illegal (Levi & Portwood, 2011; Levi & Loeben, 2004).

There is a need, in a just society, to ensure that people are not only allowed freedom, but are protected from abuse and exploitation (Gooding, 2021). When it is apparent, as it is here, that a particular inherent trait makes one more vulnerable to abuse and exploitation, it becomes a moral imperative to attempt to address the cause.

A complicating factor is that mental health discourses flatten any distinctions between different “types” of people with mental health problems. People with mental health problems are an enormously diverse group. This is partly due to the ambiguity of what constitutes mental illness or mental health problems in the first place. Policies and strategies that seek to address mental health/illness in its entirety are bound to fail when attempting to resolve the incompatibility between the two discourses. This constitutes a significant flaw in Scotland’s mental health service strategies, and the policies that arise from it. People with mental health problems have the right to autonomy and freedom of choice – in the literature this right is often used to explain why they should be allowed to make even poor choices, or choices health service providers may otherwise disagree with. However, they also have the right to the maximum attainable standard of health and mental health. It is also true that health services providers have a positive obligation toward enabling these rights. Therefore, health services providers should not only passively allow people with mental illness or mental health problems to exercise their rights to choices, but ought to be actively changing systems to enable the right to the maximum attainable standards of health.

The conclusions of this thesis are that a potential solution to these dichotomies lies in re-emphasizing rights in mental health strategy and policy: not only the right to autonomy but also the right to maximum attainable level of health and right to safety. There is an opportunity to strategically employ argumentative discourse to emphasize these rights within the next Scottish mental health strategy and related advertising. Similarly, there is an opportunity to embed Rights-Autonomy Discourses in policies governing care of people with mental health problems. Finally, there is an opportunity to further emphasize Rights-Autonomy Discourses in professional mental health education (such as medical, nursing, and social work).

The Rights-Autonomy Discourses can be strategically emphasized with the intent of creating new identities for people with mental health problems who receive services. By refocusing and emphasizing existing discourses of people who use service as autonomous rights bearing individuals, the focus can become not only on their right to choose service, but also on their other fundamental rights: namely those rights in which they can live life free from abuse and exploitation, free from being treated unfairly due to their circumstances. Enforcing these rights, to which we have positive obligations, may require new policies in which service providers are empowered to intervene to protect those rights.

This ultimately means a radical re-constructing of the principles on which mental health services are based. This shift ultimately requires an acknowledgment that certain forces are not simply old fashioned, but that commitment to them actively impedes an ability to propose actions that are protective and promoting of human rights in persons with mental health problems, and who use mental health services.

This will be done by recommending expanding the use of Rights-Autonomy Discourses in a strategic manner to mental health strategies (and subsequently to policies and to public communications). An argument is presented, that addressing the problem within the framework of human rights-based health services would be highly productive.

This would facilitate progress toward empowerment of people with mental health problems such that they can speak of themselves in a way that holds influence in broader society – wherein their voices hold significant influence in the way services are designed and delivered. This vision though, should be held as an ideal end point of changes instituted within mental health services.

1.6 Structural Overview of Thesis

This thesis is structured as follows: The second chapter contains the focused literature review, in which the relevant topics are explored and their links to one another and to this study are discussed. Chapter 3 outlines the theoretical orientation or lens that informs the study, discourse analysis as the chosen methodology, and a description of the methods that were used in the data collection and analysis.

Following this, the thesis is divided into 2 broad sections. First, in Chapters 4,5 & 6 I outline the processes and results of the two phases of documentary data analysis. Following this, I apply aspects of the discourse-historic approach to the critique of Scotland's mental health strategy and make recommendations for future directions (Chapter 6), which are informed by the analysis of the Strategy and the inter-textual themes present in the archive of documents relevant to mental health services. Chapter 6 also serves as a set of general recommendations. Chapter 7 serves to revisit the topic of non-criminal exploitation. Using a framework of exploitation informed by the literature, and guided by an understanding of discourse, it discusses some pragmatic ways the issue can currently be addressed in mental health policy. Chapter 8 serves as a brief summary, reflection, and conclusion.

1.7 Interlude: Contextualizing the Thesis for the Reader

At its earliest stages, this thesis project was conceptualized and developed with the aim of exploring and describing the social forces that marginalize individuals with mental health problems such that they are vulnerable to

exploitation by others, and more specifically to forms of exploitation that do not reach the threshold of criminal abuse. The initial intention of the project was to also examine the nature and effectiveness of the resources that mental health service providers might have available to them to assist people with mental health problems in exploitative relationships. The thesis does this, but the route between the thesis proposal to this dissertation was more challenging, circuitous, and in the end hopefully more interesting, than initially anticipated.

As described above, this thesis was designed with the aim of examining the issue of non-criminal exploitation of persons who live with mental health problems. The issue on non-criminal exploitation was chosen because criminal exploitation is a matter of legal intervention and thus exists in a different sphere, where legal interventions become more easily engaged. I chose to specifically explore the space below the threshold of criminal exploitation, and why it might be enabled within society as well as by providers of health care services, albeit without ill intention or conscious decision.

In the course of planning this thesis project, I set out to determine how policy documents underlying health care services in Scotland frame the problem of noncriminal exploitation of people with mental health problems. I also sought to determine and what interventions were available to people who work in mental health services in events of noncriminal exploitation among the persons who use their services.

Early on, during the collation of literature, I found that the issue of noncriminal exploitation was in essence fully absent from discourses in mental health service provision. In fact, no forms of exploitation are discussed or addressed directly in these discourses. Further, detailed reference to any abuses of people with mental health problems were overall absent from health service discourse, and were not presented as “issues” or “problematic” in any substantial or meaningful way. That is, they were not targets of action beyond projects or procedures aimed at destigmatization. This is in contrast to the

fact that that throughout the discourses in mental health services, *concern* for the vulnerability and safety of people with mental health problems is expressed clearly. Despite the expression of these concerns, there are very few substantial, or even minimal, interventions prescribed for practitioners.

This naturally constituted a significant barrier to the intended research. Constructing a thorough literature review (Chapter 2) thus consisted of using creativity and inference, and required exploring parallel issues and the commonalities they held with the problem of non-criminal exploitation. This includes how exploitation is defined in various fields, the relationship between mental health problems and marginality, and the increased likelihood of marginalized persons to experience forms of exploitation. I explored potential barriers to health service providers in reporting exploitation of persons with mental health problems. This literature review led me to the conclusion that underlying the issue of exploitation is, quite naturally, issues of power. It was this that led me to choose discourse analysis as my methodological approach to explore the issue further.

The planned approach was (in part) to first gather an archive of documents related to mental health services, users of mental health services and exploitation. I wished to uncover the ways in which mental health services officially described exploitation and the risk of exploitation among persons with mental health problems. I had planned to use this to describe how discourses construct roles and identities of people with mental health problems as victims of exploitation, or victimizable.

Once again, the result of this analysis was that there was no such construct apparent in the archive I collected, either explicit or tacit. Despite there being ample discussion around the exploitation of other vulnerable groups, there was almost no discourse to be found directly related to exploitation of people with mental health problems.

Exploitation is a very difficult concept to define, and it is firmly embedded in discourses of vulnerability. But what was surprising to me was that there is

ample discourse describing people with mental health problems as vulnerable. However, unlike other vulnerable populations (disabled persons, older adults, children, migrants, etc.) there was no exploration of this form of possible abuse. The absence of this discourse of course means that there is similarly no discourse, formal or informal, about the vulnerability of people with mental health problems to exploitation. The absence of these discourses is striking, and worthy of further exploration. It is this resulting exploration of the silent space in the discourse that makes up the bulk of this thesis. I chose to examine the spaces related to the issue, largely with the intention of explicating the issue of exploitation of persons with mental health problems, and to propose potential actions that could be implemented by mental health services to help people with mental health problems in vulnerable situations.

This gap in the discourse necessarily became the focus of this thesis project. Thus, this thesis focuses, perhaps unusually, on the effect of a *lack* of discourse, on the effects the lack of discourse has on health care services, and how it reveals both a substantial gap in mental health services, and untenable tension between the stated values of mental health services, and the services that are actually provided to people with mental health problems in Scotland.

As such this thesis unfolds in the following manner: I explore exploitation and demonstrate the lack of attention to the issue in the documentary archive, and examine related issues. Because of the “official silence” on the subject, I then examine the overall archive in search of a reason for the silence. In doing so, I uncovered a larger tension in the discourses that makes it difficult to propose actionable solutions to the problem of exploitation. Thus, the bulk of this thesis is devoted to describing this tension in the archive and demonstrating how it plays out in Scotland’s mental health strategy. Finally, I return to the issue of exploitation, with this understanding in mind. I discuss how the tension between competing discourses embedded in mental health services in Scotland interferes with discourses and actions intended to be

helpful for people experiencing exploitation as a result of their mental health problems.

Chapter 2 Literature Review

A literature review was conducted to gain an understanding of the field of knowledge on the identified topic of exploitation of people with mental health problems. This literature review was conducted to explore the foundational concepts at the heart of the study, and to elucidate the relationships between the concepts. The literature review is intended to provide a broad understanding of issues that inform and affect the central issue. It is not a systematic review or meta-analysis. A thorough search of the literature on the topic of exploitation *of* people with mental illness, in which exploitation is antecedent to the exploitation, identified that this was virtually non-existent. Thus, the review was built on an understanding of certain central themes and developed outward from there. The process used is described below. A more thorough description of the approach is presented in Appendix A.

The literature review describes the foundational understanding of the political, historical, and cultural factors influencing the issue at hand, which is necessary in order to properly conduct critical discourse analysis (Fairclough, 1995). The review is used to draw out the relevant connections between the core concepts in a manner that demonstrates the logical connections between them and provides the justification for this research project. And finally, to provide a foundational understanding of these concepts that is necessary to inform the analysis of discourses. At the end of this literature review, a coherent definition of exploitation is presented.

In each section, I address the foundational concepts individually, outlining the literature associated with each, and briefly highlighting the relationships and overlaps between concepts and academic fields of study. I begin by exploring the concepts of exploitation and vulnerability, especially as it relates to mental illness. Then I progress to discussing concepts of power and power relationships. This leads to discussions around mental health systems and human rights. I conclude the first section by outlining the empirical evidence that exists that supports my argument that exploitation is a specific concern for people with a mental illness diagnosis. The sections that follow provide

contextual information that supports the discourse analysis that is conducted and described in Chapters 4 and 5, and especially supports the analysis that occurs in Chapter 6. This includes an overview of the political, social and historical contexts of the documentary archive.

In various places throughout the Chapter, and again in the conclusions, I outline significant gaps found in the literature on this topic. The most significant of the gaps is in describing experiences of exploitation of people who have a mental health problem. These gaps are used to formulate the research questions (Lingard, 2018).

2.1 Search Strategy

The literature review was conducted primarily using the University of Edinburgh's library resources, both electronic and physical. Literature relevant to the foundational concepts was discovered throughout a range of academic disciplines, and thus this literature review spans the fields of sociology, psychology, law, philosophy, bioethics, medicine, psychiatry, social work and nursing. As such, I did not limit the databases utilized in the first search of literature. Rather, for each search term, I allowed the search engines to search all available databases. This of course means that the number of databases used is too lengthy to address here. Rather, I will address the strategy used to address each individual topic area. See Appendix A for details of the literature search strategy and parameters used.

Once some general literature in each topic area was found, I utilized the knowledge gained to focus the literature search on publications from specific disciplines. I did this primarily by use of refined search terms and Boolean operators. I also extensively utilized "backward citation chaining, which is particularly useful when dealing with small bodies of literature (Akin, 1998). Finally, the literature review, much as the overall research, was iterative and continued throughout the research process. Topics were added as they became relevant.

Here, I briefly outline the search strategies for literature in each topic area. These strategies represent the first stages of the review, from which the rest of the literature review expanded as my understanding of the issues were refined:

- Exploitation: To search for publications relevant to exploitation, I examined publications especially in the disciplines of philosophy, law and healthcare. I fleshed out the issues related to defining exploitation and settled on a working definition. The initial use of the search term “exploitation” resulted in numerous publications on the topic of exploitation of people but few publications addressing the nature of exploitation itself. In order to develop a definition of exploitation, I generally searched for philosophical publications on the topic of “exploitation”. From there, I refined the search terms to include “abuse” and “mental illness”. I also focused on searches for “exploitation” in legal studies to inform how exploitation is dealt with in law.

- Disability and Marginalized communities; specifically literature from global health. This informed how I understand power relations between so-called vulnerable communities and the societies in which they are embedded.

- Critical approaches to mental health and illness, and how mental health/illness discourses in western society are related to power dynamics. I especially focused on the work of Foucault and Thomas Szasz.

- Power; I read introductory material on the subject of power to gain a deeper understanding of the different ways power can be defined, understood, and analysed.

- Social Contract Theory: I engaged in readings on this subject to inform my understanding of how healthcare service providers are empowered and legitimized by formal government structures.

- Review of empirical studies related to exploitation (health and law), including understanding issues related to reporting episodes of exploitation.

- Survey of legal structures that underlie exploitation and reporting of exploitation by healthcare workers. I was able to gain an understanding of which international, national (UK) and local (Scotland) legislation is relevant to understanding the issues related to exploitation. This includes so-called hard and soft law (namely, laws as well as policy and professional practice guidelines). This information will be extremely important in the analysis of data in a critical discourse framework.

- Human Rights: My readings led me to understand my thesis was naturally embedded in human rights issues. As such, I read a variety of documents that underlie human rights frameworks (for example from the UN), as well as how human rights informs new approaches to healthcare (from the WHO, rights-based approaches to health and mental health). I also read a number of articles regarding how research in human rights is best undertaken – this led to my realization that a) interdisciplinary approaches are needed, and b) any work in this area requires me to be fluent in the legal issues in the area.

The literature search was undertaken mostly online. Articles, reports, strategy and policy documents were located and accessed online. Books were located online and were accessed online or physically (through library loans or purchase).

The University of Edinburgh library, websites and search engines such as Google were used to access literature databases, policy and strategy documents. The literature search was limited to English language. In some cases, dates were not limited in order to search for historical records.

For the literature review, mostly academic and peer reviewed documents were searched (as such, most searches were limited to ‘peer reviewed’ and ‘books’). However, in some cases strategy and policy documents were sought. These were generally found through Google searches.

Titles, abstracts and keywords were screened for relevance. Also noted were the source of the article (namely, coming from reputable publishers). Currency of the articles were noted where relevant (noting that in certain cases, historical documents were specifically sought out). Additional searches were undertaken to ensure up-to-date information.

Articles excluded from the literature review included studies conducted in countries with little alignment with the UK system or cultural context. Also excluded were articles discussing exploitation from perspectives outside of social, psychological and mental health contexts (namely from biological, computer sciences). However I was careful not to overly limit my searches as topics from fields such as philosophy and other humanities were directly relevant to many of the concepts investigated. As such, the initial search parameters were deliberately left very broad.

In each case, searches on various topics were conducted first broadly using DiscoverEd and then Google Scholar. Following the retrieval and review of a number of articles that helped provide context for the coverage of the topic, further searches were conducted narrowly in specific databases, namely PubMed, and at times EBSCOhost and CINAHL plus.

2.2 Exploitation

“Exploitation” is a philosophically slippery subject (Wertheimer, 1999). Through the literature review, the boundaries of the definition were developed for use in this study, and for further research: Most post-Marxist accounts frame exploitation within a narrative of vulnerability (Zwolinski & Wertheimer, 2017), in which exploiters leverage vulnerability to gain advantage. Literature demonstrates that people with mental illness are generally accepted as “vulnerable” legally, and more broadly at a level of common understanding (World Health Organisation, 2010). A state of vulnerability comes from requiring assistance from others to fulfill one’s needs (Goodin, 1985), and to take advantage of another’s vulnerability for one’s own gain is to violate their innate human dignity (Sample, 2003).

Exploitation exists as a feature of social systems as well as individual events (Sample, 2003). Exploitation is a violation of our moral obligations toward the vulnerable: Not only the duty to not exploit the vulnerable, but also the positive duty to develop social systems that protect against, and reduce the likelihood of, exploitation (Goodin, 1985; Sample, 2003; Wertheimer, 1999).

The nature of exploitation is accepted in philosophical literature as notoriously difficult to define and debate (Deveaux & Panitch, 2017; Wertheimer, 1996;), especially as it relates to the non-economic exploitation (Wertheimer, 1996). The difficulty in defining the concept is at least in part why there are few academic studies that have attempted to capture exploitation in a meaningful way (Wertheimer, 1999); although that may be changing, as some in the field of philosophy seek to re-engage with the topic. However, this interest remains in the realm of studies of labour and politics (e.g. Mulkeen, 2021; Mulkeen, 2020). Non-economic exploitation remains an elusive concept. While many authors of academic and grey literature (e.g. governmental strategies and policy, health services policy, and professional guidance documents) maintain that people with mental illness are vulnerable to exploitation (see for example Nxumalo et al., 2017; Poreddi et al., 2013; Elbogen et al., 2011; Black et al., 2008), or deserve protection from exploitation (ibid.), these writings contain no notable attempt to define exploitation in a meaningful way. (See section 2.3 below for further details on this point).

This paucity of literature on the subject of exploitation is indeed a recognized issue: Alan Wertheimer (1986), in his philosophical text on the topic of exploitation states that many academics had previously dismissed the subject of exploitation as being unworthy of study, and that many expressed belief that it was too nebulous a subject to be useful for practical study. Certainly, despite numerous declarations of concern about exploitation of people with mental illness throughout both academic and grey literature, it has proven difficult to provide a satisfactory definition of what is meant by “exploitation” in these contexts. Thus, the first step taken in this literature

review is to build a concept of exploitation that is useful for an exploration of the phenomenon of interest described in Chapter 1: Indeed, what does it mean to say that a person with mental health problems is “exploited”? Or to say that they are vulnerable to exploitation? It is also in the interest of this study to further define exploitation in a way that expands it beyond a simple understanding of economic unfairness, as will be further discussed below.

2.2.1 Philosophical Accounts of Exploitation and Vulnerability

Exploitation as a philosophical concept largely emerged from the work of Karl Marx (1818-1883), whose primary concern was embedded in notions of class, distribution of capital and outputs of production (Deveaux & Panitch, 2017). This influence means that in philosophical literature, the term “exploitation” was almost exclusively used to describe capital transactions (Sample, 2003; Wertheimer, 1986; Wood 1995). Many post-Marxist accounts of exploitation, even while attempting to broaden the application of the phrase to non-economic uses, continue to cleave to a transactional paradigm in order to explain the “wrongness” of exploitation. That is, in order to explain why exploitation is “bad”, many philosophers continued to explain the phenomenon in terms of transactions, and that exploitation entails unfair transactional relationships (Sample, 2003; Wood, 1995). Even some post-Marxist works on exploitation, including that by Alan Wertheimer (1986), arguably the most influential post-Marxist account of exploitation (Sample, 2003), maintain a commitment to defining exploitation as a payment of non-standard prices for goods and services, even as they attempt to account for non-economic transactions. While this does capture at least one aspect of exploitation, it seems that it is too narrow a definition to satisfactorily capture the nuances of how the phrase “exploitation” is used when concern about mental illness and exploitation are raised in discussions around mental illness and vulnerability. For example, if one examines the examples that were given in Chapter 1 (e.g. paying unfair prices, exchanging sex for a place to stay), one might certainly agree that there is a transactional element to many of these examples, but that the transactions (especially in the latter

example) could not be fully or morally be reduced to solely economic in nature. Thus, traditional Marxist accounts of exploitation do not by themselves conceptually fully support analysis of some of the types of exploitation that are of interest to this study. Further, there is a weakness in these accounts of exploitation, in that they tend to centre the responsibility for exploitation in individuals (Sample, 2003) – the responsibility for exploitation is with the exploiter, who takes advantage of an inherent vulnerability in a 'victim' (Deveaux & Panitch, 2017). This individualized concept of exploitation fails in the face of certain facts of the experience of mental health problems; namely, that the vulnerability that is experienced by people with mental health problems is strongly associated with cultural stigmatization of mental health problems at least as much as it is associated with inherent traits of people with mental health problems. Fortunately there has been some development in the literature that moves the concept of exploitation beyond the transactional Marxist account, and more towards a broader understanding of exploitation as a feature of unjust social systems.

In much of the philosophical literature, exploitation is often recognized as a structural feature of society or a system (Sample, 2003; Wertheimer, 1986; Wood 1995). This includes the view that exploitation is a phenomenon that results from economic and social systems of oppression (Deveaux & Panitch, 2017). From this conception of exploitation as a feature of oppressive social structures, exploitation can be understood as a feature of systematic unfairness, which occurs as a result of historic injustices (Sample, 2003). By reference to historical injustice, philosophers highlight the importance of the historical context in which current social structures developed. Some of these later accounts of exploitation, especially that of Sample (2003), begin to move the concept of exploitation away from purely transactional, capital-based definitions, which make it more inclusive of non-economic interactions. If exploitation can be understood to be a feature of systemic unfairness, then one can understand numerous social interactions to be inherently exploitative (Sample, 2003). This broader conception of exploitation also means we are

able to examine exploitation at levels beyond simple transactions that occur between individuals.

The key element in most normative accounts of exploitation is the necessary inclusion of unfairness (Sample, 2003; Wertheimer, 1986; Wood 1995). Unfairness occurs within the transaction, wherein an exploiter takes advantage of a feature or trait of the 'victim' in order to gain some advantage for themselves (Deveaux & Panitch, 2017). Alternatively, the exploiter may take advantage of an existing structural defect in a relationship or society to gain an unfair advantage (Deveaux & Panitch, 2017). This second example is an example of how we can conceptualize exploitation in a broader social-level sense. This allows us to analyse both individuals as well as institutions and societal relationships for features that enable exploitation.

Note that for this reason, we can see a justification for the use of critical discourse analysis in this study: Critical discourse analysis is concerned with discourses and interactions that play out at the societal level. Further, there is a concern for historical context, in both Foucauldian analysis and critical discourse analysis. This will be explored in detail in Chapter 3.

The presence of unfairness does not necessarily mean that exploitation is always purely to the benefit of the exploiter. Wertheimer (1992) argues that exploitative relationships may be immoral even if the exploited party stands to benefit – in fact the benefit to the exploitee may be key to understanding the subtly of exploitation, and how it differs from other forms of abuse. It is because the exploitee stands to benefit that his bargaining position is comparatively weak (Wertheimer, 1992). For example, a person who is struggling to pay bills may take a job in which they are underpaid and overexerted, simply as they do stand to gain some benefit from the job, even if it is wildly disproportionate to how much the employer gains in that situation. It is this imbalance between needs and resources that introduces the element of unfairness and vulnerability into a relationship. Therefore, cases of exploitation are often seemingly voluntary on the part of the

exploitee, but they remain exploitative and immoral nonetheless (Sample, 2003; Wertheimer, 1992).

Vulnerability is central to understanding these accounts of exploitation, as the exploiter leverages vulnerability to gain unfair advantage. Goodin (1986) specifically defines exploitation as the act of taking advantage of the vulnerability in another of another for one's own benefit. "Extreme vulnerability" in Goodin's account exists under the conditions of asymmetrical power; possession by the powerful of something the other needs; monopoly on what the weaker person needs by the powerful; and control by the powerful of what the weaker person needs (Goodin, 1986). The state of vulnerability emerges from requiring assistance from others to fulfil needs (this is consistent with Szasz's account of the source of psychiatric power, to be discussed later). As such, vulnerability is a feature of power within relationships, and exploitation is a violation of a prima facie moral obligation to vulnerable persons (Gooding 2021). People in positions of power have a moral duty to refrain from exploiting the vulnerable – this is generally not a subject of debate. But further, and perhaps more importantly, people of power have a positive duty to protect the vulnerable from exploitation (Gooding, 2021; Sample, 2003; Goodin, 1986). This concept of positive duty emerges later in the discussion of human rights in health care.

Sample (2003) further develops the moral argument against exploitation, also arguing that vulnerability is central to understanding exploitation. In her account, exploitation occurs when one takes advantage of another's genuine need in a way that fails to respect them as a person. In this, Sample's argument echoes Kantian notions of morality and the centrality of respect for the intrinsic value of the person (Johnson & Cureton, 2019). Exploitation is "human degradation" (Sample, 2003), wherein human beings have objective and intrinsic value, and are deserving of respect. In her account, what matters in not merely the exploitation of a person or group, but how the conditions came about that such advantage taking is possible (Sample, 2003; Zwolinski & Wertheimer, 2017). This allows us to criticize both individual

exchanges and institutions as exploitative (Zwolinski & Wertheimer, 2017). It is also consistent with the position that exploitation is a violation of human rights. This position is developed in this thesis.

As a part of a commitment to human rights, state institutions have a positive obligation to protect the vulnerable, as described by Gooding (2021) and others (e.g. Williams, 2002). There are challenges to translating these obligations into practice. To wit; under what circumstances is the state justified in refusing or prohibiting exploitative transactions/interactions? There are clear cut cases wherein a relationship is both harmful and non-consensual – in those cases, there is prima facie wrong, and the state has an obligation or justifiable right to act to intervene (Wertheimer, 1992). However, the question becomes much more complicated where relationships are consensual and/or beneficial to the exploitee, and do not reach the threshold of reportable abuse. It is these latter cases that are of interest to this study.

2.2.2 Exploitation and the Law

Outside of philosophy, much of the published literature on the subject of exploitation exists in the field of legal studies. Exploitation is generally a legal concern once it targets protected groups of individuals or violate laws. The state enacts obligations toward protection of vulnerable people through laws (Gooding, 2021). In legal literature and Scottish law, exploitation is focused on specific forms that exploitation may take (e.g. Scottish Government, 2017 b.). This includes human trafficking, labour exploitation, sexual exploitation, and financial exploitation (Scottish Government, 2017b.). Further, the concern for the exploited is often focused on specific vulnerable populations - namely children, the older adults, and the disabled. Persons with mental health problems are at times taken to be members of the disabled community, including in Scotland's laws protecting vulnerable persons (this relationship will be discussed further below) (Scottish government, 2007; Williams, 2002). These specific forms of exploitation are deemed criminal (Scottish Government, 2017b.; 2007).

Interestingly, though one would assume that criminal definitions of exploitation would lead to clear expectations for health services providers, this does not prove to be the case – a fact gleaned from extensive searching of available policies and guidance documents conducted for this study (the process used for this search is described in detail in Chapter 3). What is evident in the literature, is that among health service providers who are responsible for reporting instances of exploitation that they encounter in the course of their work, there is rampant confusion and inconsistency in reporting. Researchers have found that many professionals who are "mandatory reporters" of abuse and exploitation in fact are not clear on their responsibilities and the legal expectations on them (Levi & Portwood, 2011; Levi & Loeben, 2004).

Laws and policies require cleanly defined concepts to be of use – in the absence of this, inconsistent application and confusion among enforcers of those policies occurs (Levi & Portwood, 2011; Levi & Loeben, 2004). This is manifested in pervasive issues related to reporting criminal exploitation. People who work at point-of-care, and who are legally required to report instances of criminal exploitation to authorities, often fail to do so. There are a large variety of reasons why they fail to do so. In fact, there is extensive literature from the fields of law, nursing, social work and medicine, in which front line workers report why they fail to or choose not to report abuse of people in their care. (See for examples: Ahmed et al., 2016; Beach et al., 2016; DeLiema et al., 2015; Lines et al., 2017; Mitchell & Buchele-Ash, 2000; Rosen et al., 2017; Svärd, 2017; Talsma et al., 2015). This includes: Lack of familiarity with laws and standards (Ahmed et al., 2016), lack of confidence in self and ability to assess abuse and exploitation (Ahmed et al., 2016; Beach et al., 2016), lack of trust in the process (Svärd, 2017), and preferences to address exploitative circumstances directly with the victim and the victim's family (Rosen et al., 2017). Protection of the relationship is also important to caregivers, as is a concern for the safety of the victim (DeLiema et al., 2015; Rosen et al., 2017).

Similarly, professionals report concerns about the role of evidence of criminality and reporting thresholds: For example, there is no consensus on what the phrase “reasonable suspicion” should mean (Levi & Portwood, 2011), which is the legal standard of mandatory reporting in many US jurisdictions. According to Levi & Loeben (2004), the use of the phrase ‘‘reasonable suspicion’’ (rather than phrases such as ‘‘knowledge’’ or ‘‘justified belief’’) is intentional. It allows for more flexibility in initiating an abuse investigation (Levi & Loeben, 2004; Levi & Portwood, 2011), but the lack of consensus of what constitutes “reasonable suspicion” creates confusion and anxiety among professionals who are mandated to report abuse (ibid.).

Another issue that may arise with mandatory reporting is that there is often confusion among professionals about whose responsibility it actually is to report various forms of abuse, or what categories of abused individual may be covered by legislation. For example, when looking at the The Adult Support and Protection (Scotland) Act 2007 , many professionals report a concern with ambiguity regarding who “fits the act” (Joseph et al., 2019, p. 56) – that is to say, what type of patient does or does not qualify for protection under the Act - and which professionals are qualified or empowered to make assessments under the act (Joseph et al., 2019).

These issues with reporting are informative for this thesis. Even in cases where there exist clear reportability measures, there is ambiguity and uncertainty about how to implement legal protective requirements. Policy that is designed to aid front line healthcare workers should minimize, or at least account for, similar concerns. This research illuminates the profound issues created by embedding non-specific, poorly defined concepts into policy directives – especially those which carry the weight of legal repercussions. The framing of exploitation in the literature (and law) as solely a criminal offence potentially causes policymakers to miss opportunities to understand exploitation as something other than in criminal terms. This further reinforces the concern expressed by Wood and Wertheimer (as described above) that a

lack of a robust definition of exploitation has impeded research and policy development for exploitation.

2.2.3 A Working Understanding of Exploitation and Mental Health Problems

For this study, a working understanding of exploitation informed by this literature review was developed to guide further literature review. This was necessary due to both the complexity of the issue and the dearth of literature on the specific topic of exploitation as it relates to mental health problems. .This broad understanding of exploitation is developed and presented here to provide context for some of the further development of the literature review. It is based largely on Sample's definition described above, and further expanded using other sources of literature. This understanding was refined and expanded through further exploration of literature, and a more comprehensive and contextualized definition of exploitation as it relates to mental health problems is at the end of this Chapter.

Exploitation involves the leveraging of a vulnerability and power imbalance to extract value from a person, for one's own interests. Exploitation is a violation of the human dignity of a person. For these reasons, even if a person is consenting, or even if a person in some ways benefits from an exchange, the exchange/relationship/system may still be exploitative. Exploitation can occur within individual relationships, or by institutions. Further, these features of exploitation are assumed: Exploitation is a human rights violation. Thus, in line with human rights processes, states (e.g. governments and government-run agencies, as described below) have a positive obligation towards protecting vulnerable people from exploitation.

This working definition of exploitation, based in philosophy and law, is firmly in line with human rights theory. Namely it is in keeping with the right to not be subjected to degrading or dehumanizing treatment (United Nations, 1948). It is also consistent with the right to the highest attainable standard of health (World Health Organization, 1946) and mental health (World Health Organization, 2011). Per the WHO (2011), safety from abuse and

mistreatment, as well as a healthy relationship with a broader community, are social determinants of mental health, and thus protecting those rights enables access to high standards of wellbeing. Maintaining these rights to protection from abuse, and developing a healthy relationship with a community, are protective of mental health. Thus, a concern for exploitation entails a concern for human rights.

2.3 Empirical Evidence of Exploitation and Mental Health Problems

There has been remarkably little empirical research into the specifically defined subject of the exploitation experienced by persons with mental health problems. Database searches for numerous terms related to mental health problems/illness/health and exploitation bear very little fruit (see Appendix A, Table A.1). There is a dearth of empirical studies, or positional papers, on the topic of exploitation experienced by people with mental health problems, with the mental health problems as an antecedent of or causal factor for the abuse. Most research is on adverse mental health effects on individuals who have experienced exploitation – for example the trauma that results from being sexually exploited. These studies are generally focused on specific forms of exploitation of vulnerable persons, such as such as financial exploitation of the elderly (Gali et al., 2019; Lichtenberg et al., 2013), sexual trafficking (Acharya, 2014; Cannon et al., 2008; Kiss et al, 2015) or labour trafficking of migrants (Meyer et al., 2014).

Nxumalo et al. (2017) briefly describes how families of persons with mental illness are vulnerable to exploitation. Poreddi et al. (2013) also report that persons with mental illness report experiencing exploitation, and refer to other evidence that people with mental illness are exploited (though unfortunately do not substantiate this claim with links to other studies). Elbogen et al. (2011) and Black et al. (2008) report that persons with mental illness are more likely to be exploited financially than those without mental illness, especially as targets of scams. Again, these articles do not provide much in the way of firm empirical evidence to support the claims. Indeed, in

these articles and others, it simply appears taken as a foregone conclusion that people with mental health problems are vulnerable to exploitation.

Among the few studies that have been published on this topic found that individuals living with mental illness were regularly subjected to financial exploitation that took forms such as: Being overcharged for services; being 'encouraged' to 'share' benefits money with friends, family and acquaintances; lending money that ultimately go un-repaid (Kelly & McKenna, 1997). Additionally, Poreddi et al. (2013) describe the results of a survey of persons with mental illness and their caregivers in which 80% of caregivers and 63% of individuals with mental illness surveyed reported that they had been exploited by community members. Further, in this study, less than half (45%) of participants with mental illness accepted that they were allowed to work in fair working conditions.

Some creativity was required to find additional empirical evidence supporting the need for a study centred on a concern for the exploitation of persons with mental health problems. When one takes a definition of exploitation to include a variety of crimes (such as financial abuse, sexual abuse and property abuse) that may be understood as exploitation (given the definition used in this study), the data become clearer. It is a consensus that people with mental health problems are more likely than the general population to be abused (World Health Organization, 2010). A study of 936 patients in America by Teplin et al. (2005), for example, demonstrates that people with severe mental illness are more than 140 times more likely to be the victim of property theft, and are 15 times more likely to be the victim of sexual assault (Teplin et al., 2005). A survey by Pettitt et al. (2013) of 361 randomly selected persons with severe mental illness in England and Wales found that "people with mental health problems experienced higher rates of crime, were considerably more likely to be victims of crime than the general population and were more adversely affected by crime. They were three times more likely to be a victim of any crime and five times more likely to be a victim of

assault. Women with mental health problems were particularly vulnerable being ten times more likely to be assaulted" (p. 1).

It is also the consensus within the literature that people who belong to other forms of vulnerable groups - such as being older or having a developmental disability - are at an increased risk of exploitation (see for example, Laing, 2017; Lichtenberg et al., 2013). In addition to the evidence presented earlier that people with mental health problems can be taken to be a vulnerable group, there is a large amount of empirical evidence that establishes the correlation between the occurrence of mental health issues and vulnerability (Wilkinson & Pickett, 2010; World Health Organization, 2001). People with severe and enduring mental illness are more likely to experience major health issues and they lose upwards of 25 years of life expectancy (Newcomer & Hennekens, 2007; Vogt et al., 1994). They are more likely to experience homelessness, have low incomes, and experience drug addictions (Draine et al., 2002; World Health Organization, 2001). Despite popular perceptions, they are more likely to be the victim of a crime than to commit a crime (Teplin et al., 2005; Cummings, 2013), but they are over-represented in prison populations (Teplin, 1984; Cummings, 2013). People with severe mental health problems, especially women, are at a highly increased risk of being victims of violent crime. This includes crimes such as physical, domestic and sexual violence (Khalifeh et al., 2018). It was also reported in this study that persons with severe mental health problems were much more likely to report psychosocial morbidity post-crime than people without mental health problems (Khalifeh et al., 2018).

Individuals with mental health problems are the most likely to complete suicide (Bellack & Mueser, 1986). They are socially marginalized and stigmatized (Lai et al., 2001; World Health Organization, 2001).

As can be inferred through this literature search and review; a) people with mental health problems are a vulnerable population and b) vulnerable persons are more likely to experience exploitation. It seems a safe inference that persons with mental health problems are more likely to be exploited: And

indeed, some literature does state this as fact (Poreddi, et. al, 2013; Elbogen et al., 2011; Black et al., 2008). Through inference and a careful examination of the connecting issues, we can reach this conclusion even in the absence of a large body of literature that explicitly states this exact fact. That said, the lack of such literature is concerning, and notable. When examining an issue from a Foucauldian perspective, the data that are not present can be as important as the data that are (Gibbs, 2015). There are likely several reasons explaining the absence of published empirical data on the subject. One likely issue is the ambiguity around the definition of exploitation, as described by Wertheimer (1992) and Wood (1995). We can infer that persons with mental health problems are exploited, and that few researchers are presenting their research in those terms.

2.3.1 Interpreting the Literature: Effects of exploitation on people with mental health problems

There are two ways to interpret the data on the effects of exploitation on people with mental health problems. One way is to infer that people with mental health problems are *more likely* to experience exploitation, and of course, this is what many state (e.g. World Health Organization, 2010). That means that statistically speaking, people with mental health problems experience a higher *rate* of exploitation then the general public. Again, while many articles and organizations seem to claim this, there seems to be very little substantial data to support this.

However, there is another interpretation which is less reliant on statistics to support. This interpretation is that people with mental health problems are more vulnerable because they will likely experience the effects of exploitation more severely. This latter interpretation I believe is supported by the literature and by inference. People with mental health problems are more likely to live in economic deprivation, to have limited or no employment, and to have unsecure housing (as outlined above). Thus, when they experience exploitation, especially material exploitation, they are in position where they are less likely to be able to compensate for the cost of the goods or service

they lost. Similarly, they are far less likely to be able to afford the resources, such as alternate housing, to escape forms of exploitation that are not material in nature (e.g. sexual exploitation). As such, the effects of exploitation may be amplified among people with mental health problems.

To summarize this concept: The marginality that people with mental health problems experience may make them more likely be the targets of exploitation. This is not well supported in the literature. But given the marginality of people with mental health problems, which is well documented in the literature, we can infer that people with mental health problems will have a more difficult time adapting to the exploitation and the effects of exploitation. People with mental health problems are likely to have fewer material and relationship resources which might be protective factors. This is important to understand in the context of potential interventions, and as such is discussed further in Chapter 7.

2.4 Mental Illness & Mental Health Services

In this subsection, literature about the special status of mental health problems among marginalized groups, in medicine, and within society, is explored. I will seek to define the parameters of what is meant by “mental illness” in this context, and explicate the relationship between mental health problems and vulnerability. Further, I will explore the literature around vulnerability and the importance of understanding the concept of vulnerability in mental health service provision.

2.4.1 Defining Mental Illness & Mental Health Problems

Defining mental illness or mental disorders is a profoundly complicated endeavour – especially as it relates to health policy (Goldman & Grob, 2006). It is a task that is impossible to do justice to within the scope of this thesis. However, in this literature review I will attempt to define the parameters around which I define mental illness or mental disorder for the purpose of the study, while acknowledging this is a specific definition for a specific purpose. Further, I will attempt to capture at least some of the social, historical and

medical contexts in which society's relationship with mental illness has emerged. Additionally, I will attempt to address some of the issues and questions that are of immediate concern to the central research questions.

As discussed in Chapter 1, I have defined this study as being particularly concerned with individuals who experience "severe and enduring" mental illness. To meet the criteria of "severe and enduring mental illness", Kelly et al, (2001) state that an individual must have a diagnoses of a major mental illness (schizophrenia, schizo-affective disorder, paranoid psychosis, manic-depressive illness or major depression); of a sufficient duration (at least 1 year since onset of the disorder); and an associated disability in at least one of the following areas: occupation, family responsibilities, accommodation (Kelly, et al, 2001; Goldman et al, 1981). In the latter criterion, disability is defined as a disability sufficient to "impair serious functioning or role performance" (Kelly, et al, 2001, p. 140), which one notes, in and of itself is rife with discursive assumptions.

This definition is generally consistent with how mental illness is described in medicine and medically adjacent fields. Definitions of mental illness are often closely entwined with policy on mental illness, often demonstrating a reciprocal relationship as per Goldman & Grob (2006), in which policy directions often influence how mental health/illness are defined and vice versa. It is this definition that will generally be used to underlie an understanding of severe and enduring mental illness, in large part due to the outsized influence of medicine on the field of mental health policy.

2.4.2 Mental illness as a Disorder or a Disability?

As noted above, policy has a role in the definitions of mental illness (Goldman & Grob, 2006). It is the role of policy to provide the definitions, which should be inclusive of the boundaries of this category such that it is clear who does and does not fall within the laws and regulations that apply (WHO, 2017). However, these definitions often change, not only in response

to new data, but in response to shifting paradigms, social understandings of mental illness, and political initiatives (Goldman & Grob, 2006).

According to the NHS, the term "mental health disorder" is used to describe people who have a mental illness, a learning disability and/or a personality disorder (NHS, 2018). Mental illnesses and mental disorders resist categorization. There are ongoing debates about what conditions should be included within the definition of “mental disorder” (WHO, 2017). This is further complicated by the large number of influences on the definitions.

While mental illness and mental disorder are not necessarily interchangeable, the lack of clarity between the two may lead to confusion for individuals who must enact policies and procedures directed at persons with mental illness (Goldman & Grob, 2006).

As a general rule, the term “mental disorder” is a more broadly applicable term which may encompass mental illnesses. But it also encompasses intellectual disabilities, personality disorders, and learning disabilities (as above from the NHS). At the same time, some of these conditions, notably intellectual disabilities, are often subject to their own unique sets of laws, policies and procedures (Redly et al., 2019). Further, inclusion of personality disorders has been contentious (WHO, 2017).

And to complicate this issue even further, “mental disability” is also variably used interchangeably with the term “mental disorders”, or as a distinct set of conditions (WHO, 2017). In the ICD (The International Classification of Functioning, Disability and Health), disability is defined as “an umbrella term for impairments, activity limitations, and participation restrictions” (WHO, 2019). This, naturally, would encompass some but not all mental illnesses.

For the purposes of this study, “mental illness” will be used to describe individuals with severe and enduring mental illness as described above, unless otherwise specified. However, it should be understood that this is

done only as a means of clarity rather than as a commitment to the reasoning behind the categorization.

Further, as a more general term, the more broadly accepted “mental health problems” will be used in the rest of this thesis to capture all of these various categorisations, with no judgment towards the severity or impact of the problems. As noted previously in Chapter 1, where the term “mental illness” is used, it is intended to capture a more specific level of severity and/or relationship with medical systems. Where quotations or direct references to literature are used, the original language of the author will generally be retained in order to most accurately capture their intended meanings.

2.4.3 Mental illness as Vulnerability

As seen, vulnerability is a central feature of exploitation. People who belong to vulnerable groups are at an increased risk of exploitation (see for example, Laing, 2017; Lichtenberg et al., 2013). Vulnerable populations may be defined as those at some degree of disadvantage, which require increased care, special considerations or augmented protections (Shivayogi, 2013).

Here I will explore the literature supporting the notion that people with mental health problems are members of a vulnerable group (Johnstone, 2016). This claim is strongly, if not always explicitly, supported in the literature. Vulnerability in people with mental health problems emerges from a variety of factors. It may be inherent in the individual, and due to symptoms of mental illness that can cause compromised cognition, insight and judgment (American Psychiatric Association, 2013). It may also be a result of social inequities and prejudice. Specifically, people with mental health problems are often subject to stigma, which leads to social marginalization (Johnstone, 2016; Lai et al., 2001; Poreddi et al., 2013; World Health Organization, 2001). Stigmatization can be used as a tool of power in relationships, in which others use stigma to exert control over individuals with mental health problems for the purpose of exploitation (Link & Phelan, 2014). Stigma often leads to social isolation (Williams et al., 2018; McCann & Clarke, 2004), and

dehumanization (Johnstone, 2016) which compounds vulnerability. At the same time, formal and systemic supports and services for people with mental illness are severely limited (World Health Organization, 2011). This increases the isolation of people with mental health problems and reduces the likelihood of receiving help (Pettitt et al., 2013) and of asking for help from authorities (CPS, 2019). Social marginality and ill health compound one another (World Health Organization, 2011). They are understood to "form an unholy dyad" wherein people with illness are marginalized, and those who are marginalized are more likely to be ill (Ecks & Sax, 2005).

The picture that emerges when one examines characteristics typical of those experienced by people with mental health problems, is one of a community that has a high degree of vulnerability to exploitation. They are more likely to be targets of exploitation by others (Poreddi et al., 2013), as they have more avenues of need that an exploiter may leverage (e.g. they may have need money, or shelter, or transport to health appointments, or access to substances to which they are addicted). Because of their greater needs, they are more likely to be active participants in exploitative exchanges to fulfil those needs, as described by Wertheimer (1986). At the same time, their status as a stigmatized population means they are less likely to be identified as exploited. That is, people with mental illness are often reluctant to report that they are victims of crimes or seek help from social services. Further, many individuals report not being taken seriously when they do report victimization (Pettitt et al., 2013).

2.4.4 Discourses of Marginality, Vulnerability, and Mental Health Problems

The literature around the topic of "marginality" offers a way to understand the relationship between vulnerable people and society, and is especially relevant to the experiences of people with severe and enduring mental illness, as they can be understood to be a substantially marginalized group (Pescosolido, 2013).

Marginalization is a social process of relegating people to differing or lessor status, especially as a group in relation to larger society (Granger, 2013). Using marginality is a helpful way of framing and understanding the issues faced by a group of individuals who are generally seen to be outside of "normal" society, as people with severe and enduring mental illness so clearly are. Unfortunately, there are issues with the use of marginality as a basis of understanding. Marginality discourse is often paternalistic, situating the marginalized on the outside, in need of help from those at the centre (Goodin, 1996; 2003). This framing of marginalized people is disempowering and ironically can be further marginalizing.

The framing of issues around "marginality" is further complicated by the rhetoric that emerges from it, which is around "inclusion". Researchers have noted problems with associated rhetoric framed around "inclusion" in that it creates a dynamic in which the focus is on margins, and allows for broader society to ignore obligations towards groups that are "within" the margins, even if just barely (Goodin, 1996; 2003). Inclusion rhetoric can be largely self-defeating, in that it often reinforces the marginality that inclusion efforts are designed to mitigate (Goodin, 2003).

Similarly, there are complicated issues surrounding the use of the phrase "vulnerability" and "vulnerable" to describe individuals, especially to describe people with mental illness (Amroussia et al, 2022). For example, it can be seen as a "paternalistic label that can reinforce stigmatization and social inclusion" (ibid., p. 7) As with marginality, the assigning of a group the status of "vulnerability" sets them apart from "normal" members of society, which can have ramifications. This can create the conditions for singling out "the vulnerable" for specific interventions (Amroussia et al, 2022), including legal interventions (Brown et al, 2017). This is particularly relevant to concerns around mental health problems, wherein "vulnerable persons" can be subject to unique rules designed for their own protection, especially as the use of the term generally connotes weakness rather than empowerment (Brown, 2011). It is also true that "vulnerability" is not generally a term that conveys specific

meaning, and in fact is vague and malleable even in policy useage (Brown et al., 2017). Some argue in fact that vulnerability is embedded in concepts of "deserving and undeserving" citizens (Brown et al., 2017; Brown, 2011) which is reflected in the use of the term in many policies targeting people who are marginalized (ibid).

As will be seen with marginality, and as we have discussed above in the literature with exploitation, defining who is vulnerable, and when is complex. Fineman (2021a) offers a theory of vulnerability that is helpful to understanding not only the state of vulnerability of an individual, but also in understanding the role of the state in providing protections toward the vulnerable. In this theory vulnerability is "a socially and materially dynamic vulnerable legal subject, based on a richer account of how actual peoples' lives are shaped by an inherent and constant state of vulnerability across the life-course" (Fineman, 2021b, para. 1). Thus vulnerability is a feature held by all persons, but is a fluid and relational state (Fineman, 2021a). That is, in this theory, vulnerability is universal, and that the state of vulnerability should be seen as something that changes in relation to circumstances and within relationships (Fineman, 2021a; 2021b). According to Fineman, the state has legal obligations to protect people in their most vulnerable states (Fineman, 2021a).

Similarly, there are recent moves in the literature toward reconceptualizing marginality to a radically relational concept (Ecks & Sax, 2005). In this understanding, people who are marginalized are unique, with their own views and attitudes, boundaries, discourses, and ideas of marginalization and marginality (Ecks & Sax, 2005), including whether or not they themselves self-identify as marginalized. This is the theoretical approach to marginality that I wish to highlight for this study, and why I continue to appeal to marginality as a feature that is important in discussions about exploitation and persons with mental health problems.

Issues related to exclusion from the "norm" are central to the experience of people with mental health problems. As outlined in previous sections, the

relationship between people with mental health problems and society is deeply problematic, and manifests in numerous issues related to stigma, criminal victimization and access to help and resources.

These theories of marginalization and vulnerability illuminate the concept of exploitation in the context of mental health problems; and how exploitation and mental health problems are discussed, defined, enabled and researched within a traditional, paternalistic health services environment. On one hand are conceptions of marginalized people as holders of power, whose status as human rights holders are central to respectful care. This conception of persons with mental health problems - as members of the disabled community - are consistent with a human rights-based approach to health. In this case, concepts of vulnerability (and exploitation) are fluid and relative. On the other hand, are the more paternalistic conceptions of mental health and rights that constitute mental health acts and legislation, and much of the structure of current mental health service in practice. In this approach, service providers, exemplified by the psychiatrist, hold power and legitimacy. In this case, vulnerability is a legal concern, and is directly related to the illness of the patient. As such, the vulnerability (as a symptom of illness) is defined by psychiatrists and other health service providers, as discussed next.

2.4.5 Power and Legitimacy of Mental Health Services

Power and legitimacy are best understood not as inborn traits of an individual or system, but rather as a characteristic of relationships between social entities, and a feature of social processes (Hearn, 2012). Thus, here I examine power as existing within the ongoing relationships between groups (people with severe and enduring mental illness) and society, and those services that represent broader society (such as mental health services and other services for marginalized persons).

Michel Foucault's (1926-1984) work forms part of the basis of this study, conceptually and methodologically (see for example Foucault, 1965). Much

of his work falls at the intersection of psychiatry and power. For Foucault, power is embedded in relations (Iliopoulos, 2012), and the grounding of legitimacy in society takes the form of statements that are deemed "scientific". Government, policy, law and politics are permeated by discourses which lay claim to scientific truth (Iliopoulos, 2012). These discourses are what lie at the heart of modern structures of mental health service. Foucault states that power in mental health services is self-perpetuating, built around the power of the psychiatrist to define what constitutes valid knowledge (Swerdfarger, 2016). The alignment of psychiatry with medicine and psychology has granted it further legitimacy, despite the oft-times ill fit of the practices (Szasz, 1994; 1997). Alternative discourses are presented as "irrational" or "unscientific" – in this way the dominant discourse defines itself in contrast as "rational" and "scientific" and maintains hierarchical power relations (Swedfarger, 2016).

Increased emphasis on patient freedom and rights is a direct challenge to the power of psychiatry (Iliopoulos, 2012). Language around "risk" and "dangerousness", prioritizing "right to treatment" over "right to freedom" is designed to centre/re-centre power within psychiatry, and therefore preserve its legitimacy (ibid). This can be explicit: Thomas Szasz (1994) quotes a psychiatrist thusly: "We need to lobby for the power to detain and treat the mentally ill involuntarily… for a fair way to help recalcitrant psychotics to help themselves… [this will] advance psychiatry's credibility" (p.135).

Thomas Szasz (1920-2012) is considered by many to be among the most influential critics of modern psychiatry for fundamentally mis-categorizing mental illness (Chapman, 2023) and his work has recently been seeing a resurgence in popularity in the field of critical psychiatry (Chapman, 2023). While many of Szasz's core arguments have waned in popularity in the critical psychiatry field – such as his assertion that the "suffering" of people with mental illness can often be attributed to attempts at avoidance of responsibility (Chapman, 2023) and that mental illness can be classified as a "problem of living" rather than genuine illness – some of his arguments

remain popular, such as his criticisms of the power of psychiatrists over the patient. Szasz argued that psychiatrists differ from other physicians by virtue of the power they wield over patients, and mental health patients differ from medical patients by virtue of their “economic dependence and social deviance” (features of vulnerability) (Szasz, 1994). He argued that there are two sources of power embedded in psychiatry and are wielded by psychiatrists (and, arguably, other mental health professionals): Domination and Dependence. Domination is the power to coerce a person through force, which can be enacted through the power of the state (such as those powers granted in mental health acts). Dependence, however, is the primary source of power of the field of psychiatry (Szasz, 1994). Power from dependence emerges from suffering, such as an unfulfilled need for food/shelter/drugs or unalleviated anxiety. Those suffering are often dependent on those with power to alleviate the suffering (Szasz, 1997; 1994). The power of psychiatrists is legitimized by the state by appeal to safety: patients must be protected from themselves, and society must be protected from those with mental illness. This power, granted as it is by the state, is political (Szasz, 1994).

This is further evidence of the fundamental tension emerging as paternalistic discourses around mental health problems come up against human rights-based care, global perspectives on mental health problems, and consumer empowerment movements. Foucault’s work gives us an opportunity to centralize the voices of those with mental health problems to re-examine traditional views of mental health problems and mental health service (Swerdfager, 2016; Iliopoulos, 2012).

As noted above, there is a developing and influential anti-psychiatry and critical psychiatry movement in academia, the goal of which is liberatory (Chapman, 2023). In the United Kingdom, the Critical Psychiatry Network was established in 1999 and has grown since to encompass a range of professionals who share a concern with over reliance on psychiatric classifications and with the medicalization of mental disorders (Moncreiff,

2008). There has been an ideological shift from Szasz's work in recent years to a larger concern with emancipation of people with mental health problems from a system that can be oppressive (Chapman, 2023). These concerns are in many ways aligned with the shift in focus towards human rights in mental health services.

2.4.6 Disempowerment of Service Users

Service users have consistently reported feelings of disempowerment within mental health services. Despite commitments to change services in various ways towards increased engagement of service users, and improved respect for personal choice and liberty, these reports of disempowerment remain common (Cowan, et. al, 2011). Holltum (2016) identifies that service users have reported difficulties questioning the authority of service providers, even when the users identify that they hold greater knowledge or awareness of their own circumstances. While shared decision making is promoted in the United Kingdom, it is slow to be implemented (Holltum, 2016).

2.5 Human Rights

Some assert that the human rights of people with mental health problems are the among the last of human rights to be formally recognized (Robertson, 2012). In this section of the literature review, I examine the principles and theories relevant to human rights and the relationship with mental illness and health care services. Further, I explore how human rights frameworks are relevant to mental health service provision in Scotland.

International human rights legislation forms the framework of rights and laws in the United Kingdom (Hunt, 2016) and in Scotland. As a member state of the United Nations, the United Kingdom has an obligation to abide (Hunt, 2016) by the Universal Declaration of Human Rights (UN, 1948), which affirms the right to the standards of living adequate for health (often taken now to be inclusive of mental health). These commitments form the basis of "hard law" that governs how the state addresses human rights obligations. Further, the United Nations (2019; 2021), along with the World Health

Organization (1948), affirms the right of all to the highest attainable standard of health and mental health.

“Soft Laws” also influence health service (Trubek, 2006). Soft laws can include professional codes of conduct and ethical codes, and employer policies, as well as various international agreements that haven’t been codified or entered into law (Greer & Vanhercke, 2010; Guzman & Meyer, 2010). These codes, policies and practices should be in full alignment with legal commitments but are not necessarily limited by them. It is these policies and practices that directly impact individuals during interactions with the health service system.

International Human Rights frameworks distinguish between rights-bearers and duty-bearers (Hunt, 2016). Duty bearers are those who have obligations towards fulfilment of rights. In the case of the right to health, physicians, nurses and social workers (among others) are duty bearers. It is these institutions and persons who must enact policy and programs related to human rights protections.

Signatory states to human rights declarations commit to respecting, protecting, and fulfilling human rights, including the right to health and mental health (Hunt, 2016). Namely, states must not hinder any factor that contributes to the right to mental health (United Nations Special Assembly, 2019). They must protect persons from violations of their rights, but just as importantly, they must create and implement structures (such as laws, policy, programs) that enable the fulfilment of the right to mental health (Hunt, 2016; Office of the High Commission for Human Rights & World Health Organization, 2008). To this end, mental health, mental health promotion, and the social determinants of mental health have been identified as priority areas of international development for the coming years (United Nations Special Assembly, 2019).

The Human Rights Act (1988) and the Scotland Act (1988), together require the enforcement of human rights codes to which the United Kingdom is

signatory (Stavert, 2016). This obligation extends not only to governmental bodies and services, but also to non-government organizations (NGO) operating within the country (Stavert, 2016). As such, the principles of the human rights treaties and conventions discussed below must be reflected in the policies and procedures of all mental health service organizations in Scotland, including those who are not directly funded or administered by the government.

Mental health services in Scotland, in the most recent Strategy document (2017) are explicitly committed to a “human rights based” approach in delivering services. This commitment, made on the recommendations from extensive consultations with service providers and stakeholders (Scottish Government, 2016) requires that service providers respect and protect the rights of users, that service users know their own rights and are able to access those rights, and that people are able to access a minimum standard of attainable good mental health (WHO, 2014).

2.5.1 Human Rights and Persons with Mental Health Problems

The Scottish government has committed to a “human-rights based approach” in mental health services (Scottish Government, 2017). While this is consistent with larger scale initiatives, such as within the United Nations (United Nations General Assembly, 2020) and the World Health Organisaion (World Health Organisation, 2021) that are encouraging governments to prioritize the rights and choices of service users, it is important to appreciate that the relationship between mental health services and human rights is deeply complex.

Various human rights conventions and treaties may be understood to be relevant to mental health service provision, and for various reasons. These treaties and conventions inform principles of rights-based care in mental health services (Wand & Wand, 2013). Here I outline the various treaties and conventions that have been identified in the literature as relevant to mental health services. This provides important contextual information for the

analysis of the aspects of human rights focus of the Scottish government. Note that each right discussed here is considered to be indivisible and inseparable from other rights (WHO, 2017). This again is relevant to understanding the need to balance rights against how mental health services currently exit and operate.

2.5.1.1 The Universal Declaration of Human Rights

The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948. There are a number of sections that are relevant to considering issues regarding mental health services. For example, numerous articles reference the right to 'equal treatment':

> *All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. (Article 1)*

And

> *Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty. (Article 2)*

Further, some articles reference the right to be free to inhumane treatment, and the rights to be free of unjust detention:

> *No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. (Article 5).*

And

> *All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination. (Article 7).*

> *Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality. (Article 22)*

As will be seen in further discussion below, some of these articles are now being addressed as part of a right to mental health services that do not impede on freedom, and allow access to the full range of positive rights.

2.5.1.2 The European Convention on Human Rights

The European Convention on Human Rights [ECHR] (1950) forms the basis of human rights law in the United Kingdom (Williams, 2002). As with the Universal Declaration of Human Rights, some articles focus on the right to liberty and to not be subject to inhumane treatment. The European Convention on Human Rights (Williams J, 2002), Article 3 is often interpreted as applying to abuse of vulnerable persons (Williams, 2002).

> *No one shall be subjected to torture or to inhuman or degrading treatment or punishment. (Article 3)*

Other sections that will be seen to be relevant are as follows:

> *1. Everyone has the right to liberty and security of persons. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: … (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of*

unsound mind, alcoholics or drug addicts or vagrants…

(Article 5)

Article 14: Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this document shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. (Article 14)

2.5.1.3 WHO Constitutional Right to Health

The WHO Constitution (1946) describes "…the highest attainable standard of health as a fundamental right of every human being." (WHO, 2017). The framing of health as a human right obliges states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, (WHO, 2017). The WHO constitution requires states to allocate "maximum available resources" to realizing this right (WHO, 2017).

2.5.2 The Right to Mental Health

The United Nations has engaged a Special Rapporteur to examine the right to the highest attainable level of health (UN, 2020; 2019; 2017). Among the reports generated by the Special Rapporteur is a series focused on the right to the highest attainable level of mental health.

The Special Rapporteur elaborates on the critical role of the social and underlying determinants of health in advancing the realization of the right to mental health. The Special Rapporteur (2019) outlines important opportunities and challenges associated with a human rights-based approach to actions on the determinants needed for mental health promotion. He argues that good mental health and well-being cannot be defined by the absence of a mental health condition, but must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment

of their rights and in the equitable pursuit of their potential (United Nations, 2019). The Special Rapporteur (2019; 2021) highlights the need for, and States' obligations to, create and sustain enabling environments which incorporate a rights-based approach to mental health. These environments, per the Special Rapporteur (2019) prioritize social connection and respect through non-violent and healthy relationships at the individual and societal level and; promote dignity and well-being.

According to the WHO (2017):

> *Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions. Paradoxically, mental health is still given inadequate attention in public health, in spite of the high levels of violence, poverty and social exclusion that contribute to worse mental and physical health outcomes for people with mental health disorders.*

The right to mental health is highlighted in various documents related to mental health services in Scotland. As will be shown in Chapters 4 and 5 especially, it is presented as a tentpole principle for future mental health service delivery (Scottish Government, 2017). The right to mental health however still requires exploration and explication (Robertson, 2012) in order to fully apply it in a meaningful way. The frameworks for human rights are well established, but there are few explicit frameworks for human rights specifically of people with mental health problems.

2.5.3 Mental Health Problems and Rights of Persons with Disabilities

While there is ample discussion of the rights of persons with mental disabilities in human rights literature, the literature is somewhat ambiguous as to whether or not persons with mental health problems fully belong to this group. This is illustrated in large part by The United Nations Convention on

the Rights of Persons with Disabilities [CRPD], which is explicitly inclusive of people “with mental health conditions” (United Nations, 2006). In much of the literature that references human rights and mental health problems, this convention is cited.

Recently released guidance on person-centred and rights-based approaches to community mental health services by the World Health Organization (2021) also generally refers to people with mental health problems as people who are disabled: The report explicitly uses the language “persons with mental health conditions and psychosocial disabilities” and goes on to state “The use of the term “disability” is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the [Convention on the Rights of Persons with Disabilities].” (p. XXVII).

However, when one examines the CRPD [Convention on the Rights of Persons with Disabilities] as well as other legal documents that address disability and mental illness (for example Scottish Government, 2007), it appears that intention is limited to protection of people *who are disabled* due to a mental condition or illness. This is not the same as protection of all people who have a mental health problems or condition – and in fact many individuals with mental health problems or other mental conditions would push back against any suggestion that their status is inherently disabling. On the other hand, Davar (2008) for example argues that the language of mental illness has been marginalizing and harmful, especially to women, and that adopting the language of disability rather than illness may provide a more positive framing for services (Davar, 2008).

This philosophical debate however is removed from the immediacy of a need to define mental illness and mental disability for the purposes of policy. As noted previously, the relationship between the various definitions of mental illness is closely tied to developments in mental health policies (Goldman & Grob, 2006). It is important in the context of this thesis to clarify the

relationship between people with mental illness and other mental health problems, and the CRPD and other legal frameworks that address disability. It would seem that numerous psychiatric professionals do see the CRPD as directly relevant to their work, and see it as an opportunity to revisit the relationship between mental health services and human rights (Puras, 2016).

2.5.4 Human Rights and Mental Health Legislation

The complexity of the relationship between mental health legislation and the human rights of people with mental health problems cannot be under-appreciated. In Scotland, the relevant mental health legislation is the Mental Health (Care and Treatment) (Scotland) Act 2003. This act will be discussed in further detail in Chapter 4.

According to the World Health Organization, mental health legislation should "protect, promote and improve" the lives and mental wellbeing of citizens (Freeman et al., 2005). The WHO advocates progressive legislation that is designed to protect and enhance the rights of the most vulnerable persons (ibid.) Legislation can be a valuable mechanism by which care and treatment are supplied to people with mental health problems, but also by which the rights of people with mental disorders and the promotion of mental health can be addressed (ibid.)

Much of the mental health legislation worldwide is dated (Freeman et al, 2005) and as such are not necessarily in line with current understandings or approaches to the rights of people. Certainly, legislation as it exists does not (and could not) encapsulate any of the newest developments in these understandings.

The World Health Organization has outlined 10 basic principles of mental health care law, which help to contextualize some of the newer principles at play (Wand & Wand, 2013). They are: 1) Promotion of mental health and prevention of mental disorders; 2) Access to basic mental health care; 3) Mental health assessments in accordance with internationally accepted principles; 4) Provision of the least restrictive type of mental health care; 5)

Self-determination; 6) Right to be assisted in the exercise of self-determination; 7) Availability of review procedures; 8) Automatic periodical review mechanisms; 9) Qualified decision-makers and 10) Respect of the rule of law (WHO, 1996). These principles provide a broad contextual understanding of the more recent foci of the rights of the service user in mental health care.

2.5.5 Human-Rights Based Mental Health Services

In any rights-based health service, policy and programmes must prioritize the needs of those “furthest behind first towards greater equity” (WHO, 2017). As noted previously, rights are considered indivisible and separate. According to the WHO (2017):

> *The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality requires states to take steps to redress any discriminatory law, practice or policy. (para. 5)*

This statement in particular may be read as requiring states to mitigate any discriminatory laws that unfavorably affect the health of people with mental health problems or mental illness.

The World Health Organization (2017) stresses that meaningful participation is a central feature of a truly rights-based health service system.

> *Participation means ensuring that national stakeholders – including non-state actors such as non-governmental organizations – are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation. (para. 6)*

The World Health Organization (2017) also states unequivocally that:

> *Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions.*

> *Paradoxically, mental health is still given inadequate attention in public health, in spite of the high levels of violence, poverty and social exclusion that contribute to worse mental and physical health outcomes for people with mental health disorders. (para. 14)*

Scotland is committed to implementing a human rights-based approach to health service delivery, as outlined it the Mental Health Strategy 2017-2027, which states a "human-rights based approach is intrinsic to actions to improve mental health" (Scottish Government, 2017, p.33; Dean, 2017). Thus, this study falls within a human rights framework, and directly aligns with mental health strategies undertaken by the Scottish Government, within its commitment to human rights-based health services. Exploitation of persons with mental health problems is a symptom of a failure or a gap in accommodating human rights. Addressing this gap will help to improve the health of communities and the mental health of citizens, while protecting vulnerable persons from exploitation that is occurring.

2.6 Historical, Social, Political Contexts of the Textual Archive

This section of the literature review engages with the historical, social and political contexts which form the basis of a) our social conceptions of mental health problems and examines various influences on that conception and b) the social context in which mental health services in the global north west have developed. This section by necessity is not comprehensive but is intended to provide some context for the analysis to follow in the study.

Knowing the context of a text allows us to engage with the meaning of it, as does understanding the characteristics of the intended audiences (Rapley, 2011). This process is akin to the Foucauldian genealogy, in which the current state of a phenomenon is investigated by its history, in order to critically examine it (Hook, 2007). It shares with the Foucauldian genealogy the intention of critically engaging with a phenomenon by understanding its origins, and how historical forces merge in our current context to create the

identities and discourses that exist now. In understanding this context and history, we can begin the process of criticizing these identities and discourses. In fact, the histories here demonstrate the ways in which the current societal status of people with mental health problems is neither inevitable nor an artifact of natural features of mental health problems, but is in many ways socially constructed.

2.6.1 Historical context

In this literature review, I examine the historical context of mental health services in Scotland and the West through the lens of two major historical events. These events are often described as major factors underlying the currents state of modern mental health services (Engstrom, 2012) in the global north west and fundamental to understanding how they have developed to exist in their current state. First, I examine the evolution of the practice of psychiatry in mental asylums (Hicks, 2003); and second, I examine deinstitutionalization in the middle of the 20th century (Walmsly, 2005). As noted above, this literature review will provide some important historical context for analysis of data in future chapters.

2.6.1.1 The historical treatment of people with mental illness throughout the Western hemisphere

The so-called “mental asylums” of the 19th to mid 20th century in the Western hemisphere were generally self-contained units, which stood far away from centres of civilization (Engstrom, 2012). These asylums were considered to be the “ideal” of care for the “insane” (Scull, 2021), developed with the explicit intention of isolating the most severely mentally ill persons from the rest of society (Scull, 2021). Though in general the process of closing them, and moving the patients/residents into community settings, commenced in the middle of the 20th century (Engstrom, 2012), the process was drawn out, with the last asylum – the Lennox Castle Hospital - finally closing in Scotland in 2002 (Walmsley, 2005).

It was around this time that the relationships between societal discourses and mental health services evolved. At this time, discourses around illness and

health were used strategically and deliberately to empower psychiatrists (Swerdfager, 2016). At this point in history, psychiatry – especially psychiatry as a *medical specialty* - reached an apex of positive reputation and therefore of influence (Engstrom, 2012; Grob, 2011). This brought mental illness and health into the sphere of influence of medicine and medical care.

Scholars have made the case that it is in mental asylums that the medicalization of mental illness and mental health became entrenched (Hicks, 2003). Patients who were previously allowed to roam the grounds of the asylum for example, were required to lie in bed and enact the role of "patient" when the "doctors" (i.e. physicians) came on rounds (Hicks, 2003). This enactment of the patient role reinforces the claims by authors such as Szasz (1994) and of course of Foucault (1965; 1980) that psychiatrists co-opted relevance and power from the reputation and practices of medical sciences, as well as of psychology (Swerdfarger, 2016). Thus it was during this early institutionalized era that the relationship between persons with a mental disorder came to be defined as "ill", and psychiatrists became the medical specialist who could treat the illness (Hicks, 2003).

This relationship and these defined roles persist despite ongoing struggles of the medical field to identify consistent biological explanation for mental ill health (Hicks, 2003). The role of illness in this context brings with it numerous implications for the relationship of persons with mental health problems and society. A result of the roles defined between the *ill patient* who is best cared for by the medical profession is that all medical professionals –physicians of all training, not just psychiatrists (Murrihy & Burn, 2005) – are empowered to diagnose and treat their *illnesses*. Among all professional bodies, physicians have come to have the utmost authority in dealing with many issues arising out of mental illness, including issues that are not within the actual facts of the "illness" per se, such as authority over the rights of individuals to move or live freely within a community (Szasz, 1994).

"Nurses" within this medicalized system are expected to behave much as medical nurses – in that their primary duty is to administer medications,

provide treatments, and report patient behaviours to psychiatrists (Hicks, 2003). Pharmacological interventions become the expected norm, as treatment for “illness” under a medical model (Engstrom, 2012). It may also be said that ill people are cared “for”. They receive care – in the example of asylums, very explicitly so, by lying in bed to wait for the physician-psychiatrist to come to “give” care (Hicks, 2003). In this way, they are recipients of service, rather than users of service. It should be noted that this issue is one that was directly challenged by the so-called “consumer” advocacy movement (Pulice & Miccio, 2006).

Institutionalization, while extremely popular in the West in the 1800s (Scull, 2021) among public and politicians alike, came under increasing criticism into the 1900s (Scull, 2021), leading to the closure of mental asylums and movement of care for people with mental illness into the community – an event known as “deinstitutionalization”. Deinstitutionalization was intended to provide a dramatic change in the relationship between people with mental illness and society (Pulice & Miccio, 2006; Walmsley, 2005). The intention was to remove them from “inhumane” (Pulice & Miccio, 2006) and “dehumanizing” (Scull, 2012) institutionalized settings into community settings (Walmsley, 2005). This meant moving individuals into group homes located within communities, into individual or shared homes with varying levels of government provided support, and finally to provide hospital based in-patient services for those who needed more intensive or focused care (Pulice & Miccio, 2006).

There are numerous accounts as to what provided the “trigger” to begin de-institutionalization. Some argue that it was a result of pressure from families of persons who lived in the asylums – early forms of the present-day advocacy group (Stroman, 2003). These families expressed profound concern about the living conditions with the asylums (Stroman, 2003). At the time, the claim was made that the discovery of effective drug therapy – namely chlorpromazine/Thorazine – allowed for more realistic community based management of severe mental illness (Scull, 2021). It is likely that

deinstitutionalization occurred as indeed as a combination of these and other factors. Due to these factors, and the general criticisms of asylums (and even growing criticisms of psychiatry), there was a loss of social and political support for asylums (Scull, 2021).

Some of the criticisms of asylums can be placed in the perspective of the social context at the time (Engstrom, 2012). Grob, (2011) for example states that many criticisms of psychiatry were (and are) a backlash against the over-reaches of psychiatry during the era of institutionalization. For example, during the era of institutionalization, some state that there was an over-estimation of just how effective psychiatric treatment actually was (Scull, 2021), and that the failures of de-institutionalization can be attributed to this over-reach (Scull, 2021). Regardless of the nuances of the loss of support for asylums, by the middle of the 20th century, there was a rapid loss of political and social support for their maintenance, and a corresponding reduction in the social cache and power of psychiatry (Scull, 2021). By the 1950s, many of these institutions had closed and were in the process of being closed, with the residents being left – by varying accounts - to be cared for in community settings, or to fend for themselves (Scull, 2021).

Community-based services had not been scaled up fast enough or to a sufficient level to provide adequate care to the individuals who left the asylums (Scull, 2012; Means & Smith, 1998). Sufficient attention had not been given to the fact that, regardless of the underlying pathology the individuals had, years of living within an asylum would have left most of them without adequate skills or resources to successfully live in a community setting with significantly less support, direction, or structure (Scull, 2021).

The deinstitutionalization movement was met with a variety of reactions from advocacy groups as well as the general public (Reaume, 2002; Means & Smith, 1998). These reactions both reflected and contributed to the discourses around mental ill health. On one hand, advocacy groups expressed satisfaction that institutions, which were ‘dehumanizing’, often ‘inhumane’ were being closed (Scull, 2021). Some of these themes were

reflected in the general public as well. General awareness in the public over the living conditions in the asylums was leading to a broader acceptance of the discourses that they were indeed ‘inhumane’. (Scull, 2021; Pulice & Miccio, 2006) This marks an example of a successful advocacy movement that shifted at least partially some of the discourses around mental health/illness in the general public (Grob, 2011). At the same time, people with mental illness continue to be met with a general sense of alarm and trepidation from the public (Scull, 2021), and have been neglected by the public and policymakers alike (Scull, 2021).

It is not insignificant that a significant proportion of individuals who lived in asylums became unhoused or moved to insecure housing, and a significant proportion ended up incarcerated (Engstrom, 2012; Cummings, 2019; Scull, 2021). Many of them became caught in the “revolving door” of mental health service services, which generally features transitioning between some combination of emergency and in-patient hospital care, incarceration, insecure housing in hotels or group homes, and sporadic community-based services (Scull, 2021).

The role that jails and prisons currently play in housing people with mental illness cannot be overlooked or downplayed. It is often stated with some irony that prisons are the leading providers of mental health care in the West (Scull, 2021). It is no coincidence that individuals with mental illness are depicted as dangerous and of no economic value to society, and that they end up incarcerated at a much higher rate than people without mental health problems (Hiday & Burns, 2010; Scull, 2021). There is a reciprocal relationship between incarceration and mental ill health as well, as would be expected.

2.6.2 The Medical Context

…the man of reason designates the physician to madness, thereby authorizing a relation only through the abstract universality of disease… (Foucault, 1965, p.xii).

The concepts of mental “illness” and mental health are difficult to define, and in fact, there have been numerous (often conflicting) attempts at defining the phenomenon (Scheid & Brown, 2006). Mental illness and mental health arguably have very little consistent meaning (Mechanic, 1999). Even some of the more coherent attempts at differentiating the different phenomena that fall under the umbrella of “mental health” have not been broadly taken up within the body of literature, instead remaining somewhat confined to academic disciplines such as psychology or sociology (Scheid & Brown, 2006). Purely medical definitions of mental illness rely on underlying disease pathologies as explanatory models, but the evidence here remains inconsistent and difficult to interpret (Insel, 2013). Much of the biological evidence points to physical and genetic elements of mental illness being only fraction of the puzzle of the nature of mental illness. This is supported by the mixed evidence of the efficacy of medical treatment of mental illness (Scull, 2021) and the parallel evidence of positive outcomes of community-based care of individuals with mental illness (Naheed et.al, 2012). Despite this, mental health services in Scotland (and indeed most of the world, as influenced by Western European care models) remains medicalized. As noted above, mental health service provision, as defined in the Mental Health Act, and in the Mental Health Strategy, is primarily under the purview of medical practitioners. Not only psychiatrists are given this role of authority under the Act and the Strategy – General Practice physicians [GP]s, even those without specialist training (Murrihy & Burn, 2005) – are as well. Further, it is medical practitioners who provide most mental illness diagnoses in the United Kingdom – according to the NHS (2022), general practitioners are able to diagnose many mental illnesses, while psychiatrists may be called upon to diagnose more complex illness. Outside of general medical practitioners, the only other professional body with diagnosing authority is clinical psychologists (NHS, 2022).

While the Strategy mentions increasing the number of GPs with some specialist training in mental health (Scottish Government, 2017), the implication is that basic medical training is sufficient to do basic assessment

of mental disorders or problems. Similarly, GPs are allowed, under the law and their standards of practice, to prescribe psychotropics in order to treat illnesses – and they do. The rate of prescriptions of many psychotropic medications has been increasing worldwide, including in the UK (Ilyas & Moncrieff, 2012). Most substantial increases in Western nations appears to be for antipsychotics, antidepressants, and anxiolytics (Ilyas & Moncrieff, 2012). GPs – by far - are the most common prescribers of psychotropic medications (as compared to psychiatrists). By some measures, around 80% or more of psychiatric medications are prescribed by GPs (Brijnath et.al, 2017; Ohayan et. al, 1998). There is also evidence that many of these medications have been prescribed for “off label” use – that is, for purposes or under conditions other than those recommended by the manufacturers (Ilyas & Moncrieff, 2012).

2.6.2.1 Medicalization of mental illness

Examination of the historical association between medicine and mental health shows that the focus on biological explanations of mental health problems, and the prominence of physicians in the care of people with mental illness, arose in many ways from the social dominance of medicine and psychiatry (Swerdfager, 2017; Grob, 2011).

Prior to the developments led by psychologists such as Freud, the label of “mental illness” or “insanity” was used to describe individuals exhibiting socially disruptive behaviours (Horowitz, 2002). Early categorizations of mental health problems in the early 1900s focused on profound perceptual disturbances such as what we would now label psychosis (Graham, 2010). This is seen for example in the diagnostic categories developed by Emil Kraepelin, which were widely recognized as the first attempts at categorizing mental illness (Graham, 2010), and encompassed what we would now categorize as schizophrenia and bipolar disorder (Ebert & Bär, 2010). “Milder” forms of psychological distress were not included in these early categories. That said, Kraepelin also was one of the first and most influential

psychiatrists to put forward a biological explanation for mental health problems (Ebert & Bär, 2010).

Sigmund Freud's work began a movement that not only furthered the project of categorizing mental health problems, but also triggered a movement toward finding deeper understandings of the causes of mental health problems, with the goal of finding treatment for those causes (Graham, 2010). While Freud's theories may not have initially been welcomed by the medical community, the notion that clear causes of mental health problems could be identified and treated caught hold in the early 20th century (Graham, 2010). While physicians who worked on mental illness were initially uncomfortable with the psychoanalytic interventions described by Freud and others (Mirowsky & Ross, 1989), in the 1960s, psychiatry nonetheless came to merge with medicine (even as, per Graham (2010), Freud's methods fell out of vogue with psychologists).

It has been suggested that a major factor in the dominance of medicine in the treatment of mental health problems lies squarely within the fact the promise of categorization and treatment is authoritative (Mirowski & Ross, 1989). With the development of psychiatry as a medical specialty came the promise that mental illness could be categorized and treated, in a similar manner as physical illness. This would bolster the study of mental illness with the accumulated expertise of the medical field (Mirowski & Ross, 1989).

Another factor in the merging of medicine with mental illness that epidemiology, became intrinsically linked with medicine (Mirowsky & Ross, 1989) as a medical specialty. With a focus on epidemiology in medicine came a concern with the concepts of incidence and prevalence in medicine and in psychiatry (ibid.). Diagnosis, and clean diagnostic categories, facilitate counting in this manner. This creates the need to create clear diagnostic categories such as those that exist in the ICD or the DSM (Conrad & Slodden, 2013). Much of the value of categorizing mental illness is related to the ability to study the illness and capture statistics such as incidence and

prevalence (APA, 2013). Hence in part, the currently dominant conceptualizations of mental health problems as “illnesses”.

Around the 1990s, neurobiology became increasingly influential. Many who study psychiatry seek to locate the biological and genetic causes of mental illness (Insel, 2013; Horwitz, 2002a; Mirowsky & Ross, 1989). Indeed, psychiatry has put forward diagnostic categories as the “preeminent measure of psychological problems” (Mirowski & Ross, 1989, p11). Many researchers believe that it is “inevitable” (Boyce, 2009) that biological causes of mental illness will be discovered and as such, there has been increasing attention and funding directed toward this finding evidence of this, including studies focusing on the neurobiology of mental illness (Insel, 2013). These developments, occurring simultaneously, may lead some to prioritize the relationship between biological causation of mental illness and diagnostic categories. That is, the argument goes, that biological causation provides the most meaningful framework for mental illness categorization.

2.6.3 The Social Context

Politicians and the general public are only partly aware of the fact that effective treatment of most mental health problems is possible. The image of people with mental health problems is contaminated with images of violence, sin and laziness (World Health Organization, 2003). Most health workers are not conversant with modern methods of treatment of mental illness and often do not possess the necessary skills to deal with it. Among them there are many who believe that the only way of dealing with mental illness is long term hospital care. In the majority of countries, including developed ones, there is no parity of care for mental and physical illnesses. Stigma of mental illness gains strength from these misconceptions and reinforces them. (World Health Organization, 2003)

Within the social context of Scotland, as with much of the world in general and the West in particular, people with mental health problems are particularly vulnerable to stigmatization. This has incredibly potent effects on

mental health service policy, as much of the information derived about mental health problems, for lay people, politicians, and professionals comes from the media (Murphy et al., 2013).

News media, for example, rather consistently portrays people with mental health problems as threats (Srivastava et al., 2018; Murphy et al., 2013). These portrayals, in the news media, of people with mental health problems as being threatening, often emphasizes that the general public needs protection from people with mental health problems (Murphy et al., 2013). Mental illness is highlighted in news stories when it is an element of criminal activity (Murphy et al., 2013). Additionally, speculation about mental illness is rife within media commentary in the most shocking or sensational crimes, in which cases, mental illness is often portrayed as explanatory (Benbow, 2007).

There is some criticism of some anti-stigma campaigns, in that many of them use imagery of individuals who are physically healthy, attractive and appear "normal". They appear "non-threatening" and are not perceived to be dangerous (Robinson et al., 2018), and these campaigns highlight their contributions to society. While this sort of campaign on one hand is intended to, and likely does, counter the narrative that people with mental health problems are inherently dangerous, it also carries a message that it is *certain types* of people with mental health problems who we are to feel compassion towards: The types of individuals who are not likely to be dangerous, who are likely to be able to maintain a successful career. In other words, exemplary figures are those who are contributors to society: They are able to function adequately to hold a job, attend educational experiences, and maintain successful social relationships and activities. These portrayals can lead to a strong sense of shame and embarrassment around mental health problems, which often impedes individuals seeking assistance for mental distress, as well as seeking supports when distress is experienced.

Perhaps counter-intuitively, anti-stigma campaigns may have some deleterious effects, though the extent of these effects remain unclear. For

example, it has been found that media focus on the biological theories of the origins of schizophrenia may actually increase perceptions of people with schizophrenia as inherently dangerous (Walsh & Foster, 2021). There is evidence that social stigma remains strong in relation to specific diagnoses – bipolar disorder for example (Budenz et al., 2020), or schizophrenia (Robinson, 2019); in fact research has demonstrated that schizophrenia is one of the most negatively viewed conditions due to its misperception (Robinson et al., 2019).

2.6.3.1 Mental Health Problems Represented in the Media

As noted previously, mental health problems is often used as an explanation for egregious and antisocial behaviours in news media (Murphy et al., 2013) There are plentiful examples in the media which reflect this tendency (Benbow, 2007). For example, there is a strong correlation in the media between drug abuse and mental health problems (Murphy et al., 2007). While experts may be able to parse the reasoning between the relationship between mental health problems and drug abuse, laypersons simply would see the association and potentially attribute a direct causal association.

Frequently, mental illness – or so-called “craziness” - is deemed within media to be the ultimate reason for any number of antisocial behaviours (Srivastava et al., 2018; Benbow, 2007). There is generally no analysis of underlying causes and exacerbating factors (Murphy et al., 2013). Similarly, there is public frustration, reflected in the media, when persons are deemed incapable due to a mental illness and thus are moved to a different judicial process than other offenders (Whitley et al., 2007). This is often deemed the person “getting away with” the crime – as can be observed in the comments sections of news articles. There is frequently speculation that the mental illness is “not real”, which is paradoxical in some ways to the other discourses of mental illness being explanatory. One study found that even in a high-profile case in which an individual was found to be not criminally responsible for an action, news articles reflected highly stigmatizing language

and inaccurate depictions of mental illness and legal aspects of criminal responsibility (Whitley et al., 2017).

The limited knowledge held by the general public in regard to mental health and illness is a major factor in the existence and perpetuation of stigma. It also limits efforts to counteract stigma through anti-stigma campaigns (Meyer et al., 2020). When mental health problems is inaccurately portrayed by the media, it compounds the issue.

2.6.4 The Political Context

Policy requires motivation. Policy makers at higher decision-making levels are often motivated by a number of factors that may or may not include “the right thing to do”. One of the primary motivating drivers is, and in many ways rightly so, popular will (Scull, 2021). While this is in and of itself a noble motivator, there are some notable and obvious downsides. Marginality, by definitions, emerges when a group is “outside the norm”. As such, their experiences and needs are generally not captured by appeal to popular opinion: it generally only occurs that in exceptional circumstances the needs of a marginalized group is raised to popular attention via grassroots advocacy.

Individuals with mental health problems thus have a hard road to attain popular advocacy to the degree that would be required to motivate political change (Scull, 2021). In the absence of popular will, then, it falls to advocates to drive change, often with much success (Scull, 2021).

Pilgrim & Ramon (2009) identify three broad phases of mental health policy development in the United Kingdom. The framework provided by these phases provides a context for the development of current mental health policy, and helps with understanding how modern mental health policy is more or less continuous with the asylum age. This continuity of policy provides an important insight into some of the discourses that will be explored in further Chapters.

First, what they call “an unbroken continuity with Victorian lunacy policy.” (p. 284), which entailed strong concern for safety and risk minimization over care and support. Secondly, a time period under the Conservative government of the 80s and early 90s, which was characterized by deinstitutionalization and a concurrent failure to adequately resource community care (as described above). And finally, the “New Labour” commitments to greater individual choice and freedoms. However, according to other authors (Cowan et al., 2011), New Labour governments failed to follow through on this commitment, and thus despite some small successes, mental health policy in actuality remained largely unchanged from the Conservative policies that defined the 80s.

2.6.5 Advocacy and Activism

The key to continue the momentum on mental health is to step up advocacy efforts. (World Health Organization, 2003). The examination of the main discourses in the archive made it clear that much of the “rights” discourse is driven by advocacy groups, advocates of people with mental health problems, and people with lived experience of mental health problems or mental illness.

2.6.5.1 The Consumer Movement

The consumer movement occurred alongside deinstitutionalization. The use of the phrase “consumer” was a way to empower the users of services. To consume mental health services implies that one can choose such services autonomously (Sharfstein & Dickerson, 2006).

Some scholars state that the so-called consumer empowerment movements formed in direct response to the abysmal conditions experienced by receivers of mental health services, which developed in the absence of advocacy (Pulice & Miccio, 2006). Others would argue that in fact, mental health services were already transforming themselves in such a way that allowed for the consumer movement to take hold (Tomes, 2006). Regardless of the nuances of this evolution, the result of the consumer movement was that users of mental health services became instrumental in advocating for

themselves and for those who will need services in the future (Pulice & Miccio, 2006). This, alongside other forms of self-help and peer support organizations, has advanced the movement of mental health services away from the historical influences of institutionalized care. It brought forward the importance of recognizing the needs and perspectives of those with a mental health problems on the development and delivery of services (Pulice & Miccio, 2006). The consumer movement may have had limited impact on major policy shifts in psychiatric practice, but the changes that were affected were important ones (Sharfstein & Dickerson, 2006). Examples of such changes are restructured admission procedures, advanced directives, and involvement of family in treatment decisions (Sharfstein & Dickerson, 2006).

2.6.5.2 The Recovery Movement

The recovery movement is possibly one of the strongest and most influential movements in the field of mental health – especially for severe and enduring mental health problems – in the new century (Anthony & Ashcroft, 2010). It emerged from civil rights movements, patient advocacy and survivor movements (Boardman & Shepard, 2012).

The recovery movement is described by Anthony (1992) thus:

> *There is a revolution brewing in the field of severe mental illnesses. . . . It is a revolution in vision — in what is believed to be possible for people with severe mental illnesses. . . . For the past century it was believed that people with severe mental illnesses must suffer a lengthy duration of severe disability, with a deteriorating course over their lifetime. . . . I am more convinced than ever that recovery from severe mental illnesses is possible for many more people than was previously believed. I believe that much of the chronicity is due to the way the mental health system and society treat mental illnesses and not the nature of the illness itself. . . . A vision of the possibilities of*
> *recovery can change how we treat people with mental*

> *illnesses even if the illness itself hasn't changed. (Anthony, 1992, p. 1)*

A recovery-oriented mental health service is one that does not focus on the illness, but rather on the experiences of the individual and their own relationship with their illness. In principle, it is "concerned with social justice, individual rights, citizenship, equality, freedom from prejudice and discrimination" (Boardman & Shepard, 2012, p. 6). Ideally, implementation of recovery principles in mental health services can reduce discrimination against persons with mental health problems, as well as their segregation from society (O'Hagan et al., 2012). It was conceived as a patient-driven process (Deegan, 2002), one that sees not only treatment, but success, as defined by the person with lived experience (Deegan, 2002).

The shift towards recovery-oriented mental health care has many implications for mental health services. For example, according to Anthony & Ashcroft (2010), a recovery framework assumes that the behaviour of people in care is generally reasonable reactions to circumstances in which they find themselves. As such, a recovery orientation entails a shift away from viewing patients as "noncompliant" or "disoriented", "obstructive" or even "violent" (Anthony & Ashcroft, 2010, p. 471), towards an understanding of the underlying experience that is leading to those behaviours. In a recovery framework, "recovery" from illness becomes defined by the receiver of services (Anthony & Ashcroft, 2010), rather than by the service providers. Thus the "treatment" of the illness is also decided by the receiver of service, with assistances from the service providers (Anthony & Ashcroft, 2010).

However, the movement is not without criticism. Pilgrim & McCrannie (2013) criticize the recovery movement for its ambiguity, and for the fact that it creates a situation in which people with mental health problems are (for all intents and purposes) called upon to accept the status quo and find meaning in 'the journey' of recovery rather than in resolution to their suffering. Others have argued that the recovery movement, while in principle sound, has been diluted in mainstream mental health services (O'Hagan et al., 2012). This

dilution, in combination with the use of the language of “recovery-oriented services” could potentially disguise paternalistic practices. Related to this concern, Tilley & Cowan (2011) specifically provide a critical analysis of the use of recovery in Scottish mental health policy, arguing that, based as it is on self-evident truths (such as the right of persons to self-determination), it occupies a “privileged discursive space” (p. 100), which could have the unintended or negative consequence of leaving it critically un-examined by policy makers.

2.7 Defining Exploitation

Supplying a coherent, robust definition of exploitation that is relevant to people with mental health problems is necessary before attempting to address the issues presented in this thesis. This allows policy makers to lay out the parameters of concerns. As noted above, exploitation is a tricky subject, and has been resistant to definition. In attempting to develop a coherent definition, and analysing the relationship between exploitation and vulnerability, it has become clear from the literature that these definitions are central to understanding the problems faced in policy, and might help clarify solutions.

As discussed above, exploitation is intrinsically tied to vulnerability in the literature (see for example Sample, 2003). This could occur either as related to the deemed vulnerable status of a person (that is, a person who is legally deemed vulnerable or socially ascribed a role of a vulnerable person), or from a vulnerable status as an inherent, relational trait (as described by the Fineman (2021)).

In the literature, vulnerability is a state created by numerous factors that affect people with mental health problems. This can include reduced access to housing and employment, marginalized financial situations, and greater interactions with the judicial system and stigma. The picture that emerges when one examines characteristics typical of those experienced by people with mental health problems, is one of a community that has a high degree of

vulnerability to exploitation. They are more likely to be targets of exploitation by others (Poreddi et al., 2013), as they have more avenues of need that an exploiter may leverage (e.g. they may have need money, or shelter, or transport to health appointments, or access to substances to which they are addicted). Because of their greater needs, they are more likely to be active participants in exploitative exchanges to fulfil those needs, as described by Wertheimer (1986). At the same time, their status as a stigmatized population means they are less likely to be identified as exploited. That is, people with mental health problems are often reluctant to report that they are victims of crimes or seek help from social services. Further, many individuals report not being taken seriously when they do report victimization (Pettitt et al., 2013).

An assumption, based on the literature review, is that risk of exploitation is mitigated by community connections, destigmatization, and acknowledgment of vulnerability without de-humanization of the victims of exploitation.

As was made clear in the analysis of the archive, the risk of exploitation is exacerbated by attempts to “protect society” from people with mental health problems: that is, rights of people with mental health problems are subject to suspension by the mental health act. Rights are also harmed by the isolation and stigma experienced by people with mental health problems (which things like the mental health act further enable).

From my understanding of exploitation that has been gained from the literature as well as analysis, I conclude that the key features of exploitation are:

- It is intrinsically related to vulnerability caused by stigma, discrimination and prejudice.
- Can include voluntary, even mutually beneficial exchanges
- Requires a power imbalance
- Requires that the more powerful party gains a benefit in greater proportion

- Requires that the more powerful party is (explicitly or not, knowingly or unknowingly) able to leverage the power imbalance created by vulnerability to gain this benefit
- Does not require exchange of material goods: can be services as well.
- Exploitation is relational and relative.
- Exploitation occurs within relationships
- Exploitation occurs when benefit is disproportionate
- Exploitation occurs when a power imbalance creates the conditions for the unfairness of the exchange
- Power imbalance in this context is systemic: it emerges from discourses
- Exploitation of people with mental health problems becomes “invisible” because of the same discourses

Exploitation is *relational and relative*. It occurs within relationships. It occurs when benefit is disproportionate. It exists when a power imbalance creates the conditions for the unfairness of the exchange. Power imbalance in this context is systemic: it emerges from discourses, but at the same time can be unseen or subliminal – below the concern of policy - because of other stigmatizing discourses that continue to marginalize concerns of people with mental health problems.

I draw a deliberate distinction here with regards to the status of people with mental health problems as vulnerable. As noted previously, the concept of vulnerability is complex and can be problematic. As with exploitation, it is an inherently relational concept. A person’s vulnerability arises from their relationship with society and others. The concept can be misapplied and misused (as was discussed earlier in this Chapter, and will be seen further in Chapter 4). Some have argued that the concept of vulnerability can in fact create conditions of isolation and paternalism (Brown, 2015). There is no question that the issues around vulnerability are shared by the issues this thesis has identified around the concept of exploitation. Caution needs to be

deployed here so as not to replicate the very conditions of othering that already exist in the discourses. As such, it is important to distinguish what is meant within the definition of exploitation by “vulnerability”. A distinction can be made between how the term “vulnerable” is deployed. In this case, the term “vulnerable” is applied to the members of a group who share a feature (in this case mental illness or mental health problems) and whose members are generally subjected to high rates of stigma, discrimination and prejudice. In this case, the stigma, discrimination and prejudice are the source of the vulnerability, and as such the vulnerability is inherently relational and fluid.

2.8 Key Points

In this literature review, a number of concepts related to exploitation and mental health problems were explored. A coherent definition of exploitation as it relates to mental health problems is presented, which will provide important context for analysis of Scottish mental health service policy and practice guidelines. Concepts that fall out from this central issue include human rights of people with mental health problems, vulnerability and marginality. Literature related to these concepts were explored. Aspects of the historical, social and political environment were also explored, which again provides important contextual understanding for analysis going forward.

This literature review establishes the evidence for exploitation of people with mental health problems. Using the literature, a thorough definition of exploitation is developed and presented. This definition informs future analysis in Chapters 4-7.

Various gaps in the literature have come to light in the literature search. The most relevant gap is the lack of literature directly addressing the relationship between mental health and exploitation, with mental health/illness being the *antecedent* factor in the exploitation. As noted in the literature review, exploitation can lead to a variety of mental health issues, and these resultant mental health issues are rather extensively addressed in the body of

literature. However, there is a dearth of literature addressing exploitation that occurs with mental health problems as one of the causal or explanatory factors for the exploitative relationship. This is in contrast to a relatively large number of studies and position papers describing antecedent factors such as age (youth or older), or intellectual disability. This gap became a foundational phenomenon that helped frame the research questions and justification for the study.

Chapter 3 Methodology and Methods

This Chapter outlines the methodological frameworks underlying the study, including the justification for the selected methodology. It outlines the methods used for data collection and analysis, and actions taken to ensure rigour.

Due to the complicated nature of this study – namely the combination of a number of specific methodologies that fall under the category of “critical discourse analysis”. This Chapter will focus on the philosophical and theoretical orientations taken, and the justification for the use of critical discourse analysis.

An overview of the different methodologies used is provided, along with a brief orientation to the individual methods. There will be some further discussion of the specific methods taken in Chapters 4 and 5. This will allow for more clarity on the actual steps taken at various stages of analysis.

3.1 Introduction

The research was designed to answer the questions:

RQ1) How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental health problems?

RQ2) How are mental health service providers represented in this relationship?

RQ3) What are the obligations – moral or otherwise - of mental service providers in addressing noncriminal exploitation of people with mental health problems?

RQ4) Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation?

When examining these issues through the lens of ethics and human rights, the role of state institutions emerges as particularly relevant for examination. As discussed in the previous chapter, state institutions (governments and their agencies) have a moral and legal obligation to actively institute policy and practice guidance in a manner that protects vulnerable persons as well as actively promotes their wellbeing (Goodin, 1996). Because of this obligation, an examination of the role of authority in mental health services is appropriate. This principle guided the selection of methodology.

This thesis uses Foucauldian influenced Critical Discourse Analysis [CDA] as a theoretical orientation and methodological framework to examine practice guidelines and the Mental Health Strategy of Scotland, and the potential effects of these texts on the lives of people who use mental health services, especially as it relates to remediation of abusive and exploitative circumstances. CDA is a methodological orientation that is concerned with power and authority: Thus it emerged as an appropriate methodological framework through which to examine the phenomenon of exploitation of a "vulnerable" group, especially given the complex relationship between this particular group and state institutions. Foucault (1965; 1980) provides an appropriate framework for critical analysis of mental health services (Swerdfarger, 2016). Critical Discourse Analysis is also used for the examination of text: In this case, policies, guidelines and the Strategy.

For the analysis, an archive of policy and related documents relevant to mental health services in Scotland was selected; 10 representative documents from this archive were analysed for discursive themes that can illuminate certain issues related to the experiences of people who use mental health services (Chapter 4). Following this, a focused analysis of the current mental health strategy of Scotland was conducted, to examine it both for internal discursive themes as well as analyse it for the presence of the broader themes which emerged from the archive (Chapter 5).

3.2 Research Aims and Objectives

This study was initially designed with two broad aims, and was further developed and refined with other aims as the study evolved. As described in Chapter 1, the initial aims were to 1) describe and understand the social-historical forces that influence how people with mental health problems are vulnerable to abuse and exploitation, and 2) understand and describe the resources available to mental health service providers, and how the service providers may – or may not - utilize these resources effectively. This study was designed to provide policy-level guidance to health service providers. The objectives were to trace discourses through various levels of the mental health service system and broader social communications, and analysing these discourses and their potential impacts on health services workers and the broader public's perceptions; and then to understand the resulting roles and identities of people with mental health problems. Secondly, the initial study design was aimed was to examine how health services service providers may be empowered to provide a solution to the problem. Thus, it was intended that the results the study would inform concrete policy proposals for mental health services in Scotland. Scotland was chosen as a location for this study in large part due to the Scottish government's explicitly stated commitment to embedding human rights principles in mental health services (Scottish Government, 2007). This was an appropriate fit, in that exploitation in any form is a clear violation of human rights (Harding & Salmon, 2008).

As will be discussed in Chapter 4, the aims were revised during the process of data collection and the uncovering of evidence. The first stage of data collection and analysis (documentary analysis and tracing of discourses) revealed gaps and inconsistencies between the major discourses that were related to the topic of exploitation.

Thus, the revised aim of the study became to examine Scotland's current Mental Health Strategy, in the context of tracing these same discourses in

the strategy. In this stage, the secondary aim was to examine potential problems and propose potential solutions at a strategic level.

3.3 Theoretical Orientations & Influences

3.3.1 Post-structuralism

This study is informed by principles underlying post-structuralism. Post-structuralism was developed in the same movement as discourse analysis and encompasses a school of thinking that holds that meanings and language are complex, fluid, and ultimately unpredictable (Hurst, 2017). Post-structuralism is closely associated with Foucault, especially his later works, and with discourse analysis. The analysis of language is central to post-structuralist approaches (Hurst, 2017). This quotation effectively sums up the essence of post-structuralism that underlies the assumptions in this study:

> *Post-structuralists critiqued structuralism's reliance on centres and binary oppositions; they questioned the soundness of ontology and demonstrated the emergence of Truth regimes; and they developed new ways of thinking about difference and identity that are anti-essentialist rather than grounded or fixed a priori. (Woodward, et al., 2009 p. 396).*

The key aspect to which I would draw attention is the notion that meaning, in a post-structuralist paradigm, is not “grounded or fixed a priori.” Further it emphasizes the questioning of “truth regimes” which emerge from essentialist meanings.

A post-structuralist approach holds that language is socially shaped rather than essentialist (Mason & Clark, 2010), and it is this principle that is relevant for this study. This provides a lens for understanding how values, beliefs, identities and roles within society (Gee, 201; Mason & Clark, 20104) can be discursively constructed. This next quotation captures the importance of the social factors that shape language (discourse):

> *… for post-structuralist-influenced critical pedagogy, language is a socially shaped resource, steeped in culturally and historically sedimented attitudes, values, and assumptions, which precedes and exceeds any single individual. It is these coagulations of social meaning that comprise discourse… (Mason & Clark, 2010, p.176)*

Post structuralists see language as constitutive. It forms our understanding of ourselves and others, and the relationships between.). The manner in which these values, beliefs and knowledge are communicated are co-constructed within society and influenced by the ways the messages are transmitted, interpreted, and received (Gee, 2014).

> *…language is the place where actual and possible forms of social organization and their likely social con-sequences are defined and contested. Yet it is also the placewhere our sense of selves, our subjectivity, is constructed (Weedon, 1997, p. 21)*

It is for these reasons that understanding the social, historical and political milieu in which a phenomenon exists and has evolved is of utmost importance in a post-structuralist informed study.

Power, knowledge and identity are understood to be co-constructed through discourse (Mason & Clark, 2010). Post-structuralists therefore actively engage with questions of power (Mason & Clark, 2010). Fundamental questions include “who gets to determine meaning of key concepts” (Mason & Clark, 2010). In a post-structuralist approach, we allow for the possibility that meaning can be contested, and that there are asymmetric relationships formed by the power to determine meaning (Mason & Clark, 2010).

3.3.2 Foucault

While Michel Foucault did not describe himself as a post-structuralist (Mason & Clark, 2010), he is often associated with the movement (Gutting & Oksala, 2021). Certainly his primary focus on power and discourse both aligns him

with the movement and made him an extraordinarily influential figure in critical studies of social institutions to this day (Mason & Clark, 2010). Foucault modelled a form of critical analysis that was committed to exchanges of and challenges to ideas (Mason & Clark, 2021), and a rejection of universal principles (Gutting & Oksala, 2021). As with post-structuralism more broadly, Foucault emphasized the importance of understanding the history of a phenomenon in order to appreciate how it came to exist as it does.

The point of a genealogical analysis is to show that systems of thinking do not result from rational or objective realities but rather through historical and social factors (Gutting & Oksala, 2021). As such, as with post-structural analysis, (and as we will see with critical discourse analysis) Foucauldian analysis relies heavily on an analysis and understanding of the historical trends that gave rise to a current phenomenon (see Chapter 2 for such an analysis of the historical trends underlying the discourses of interest to this thesis). This perspective, as above, rejects the essentialist understanding of these phenomena as being ontological truths.

This study is heavily informed by a Foucauldian perspective. Much of the methodology is in fact modified from a Foucauldian approach to discursive analysis, as described below. It is especially informed by and aligned with Foucault's work and perspectives on mental illness, or madness, as described in Madness and Civilization (1965), in which Foucault engages with the social constructions of mental illness and with what he saw as the "moral hypocrisy" of the psychiatric system at the time (Foucault, 1965; Gutting & Oksala, 2021). Foucault resisted the idea that psychiatry at the time, with its "scientific" and medicalized approach to mental problems, was an improvement over previous ways of dealing with mental illness (Foucault, 1965; Gutting & Oksala, 2021). He challenged the neutrality of medicalized psychiatric treatment (ibid.). Further, he argued that the supposed neutrality of science underlying psychiatry was in fact an exercise in power and control over the mentally ill, and born of social and moral dynamics of the time

(Gutting & Oksala, 2021; Swerdfager, 2017. This critique of mental services of the time reveals the ways in which the medicalization (that is, the centrality of “scientific” treatment – i.e. medicine) of mental illness can disguise and perpetuate the marginal experiences of people with mental illness. In short, it can at least in part perpetuate the oppression of those with mental illness (Swerdfarger, 2017).

Foucault considered how historically and culturally located systems of power/knowledge construct subjects and their worlds. “Foucauldians refer to these systems as ‘discourses’, emphasizing that they are not merely bodies of ideas, ideologies, or other symbolic formulations, but are also working attitudes, terms of reference, and courses of action suffused into social practices.” (Denzin & Lincoln, 2011, p. 344).

Foucault’s concern with the construction of identity of the mentally ill as medicalized, and his insights into the role of language (discourse) and legitimized power in the constructions of mental health problems and psychiatry, form an epistemological framework from which this study is conducted. Understanding that Foucault’s body of work is far reaching and extensive, and included a rejection of ‘modern’ (at the time) psychiatric care (Foucault, 1965), which would be inclusive of many of the medicalized practices and procedures common in Western mental health services. This thesis does not take the stance that such mental health services are *prima facie* harmful. As such, the reader should understand that this thesis specifically utilizes Foucault’s above detailed insights into the social legitimization of medicalized approaches to mental illness, the construction of power embedded in psychiatric services, and the importance of discourse in assessing these phenomena.

3.3.3 Discourse and Discursively Constituted Realities

Discourse, most simply stated, is the use of language to communicate ideas. Developments in the study of the use of language has given us a complex understanding of how language-in-use can influence, or even construct, the

identities and lived realities of individuals (Mason & Clark, 2021). Language is used with purpose, and received with purpose (Gee, 2014). Language can be selected and shaped to achieve specific goals for specific audiences (Gee, 2014). Simultaneously, individuals who receive messages bring their own expectations, understandings and even agendas to the exchange of ideas (Gee, 2014). It is thus that this exchange of ideas – discourse - can constitute, reflect and even construct a shared social reality between those who are communicating.

The elements of discourses are not only the details of language – the specific words that are used, the elements of language and syntax – but also the pragmatic elements of the way that the language is used (Gee, 2014), and the broader context of the language (Fairclough, 1995). Language (choice of words, specific turns of phrase, etc) is used by people to accomplish goals. People construct their choice of words not only to accomplish something or communicate an idea, but also to influence the understanding of their audience (Gee, 2014). The speaker and the listener co-create meanings, as well as bring their own meaning to an exchange (Gee, 2014). In this viewpoint, language forms social realities. In this theoretical orientation, language does not simply communicate the nature of reality: Fairclough (1995) describes language as “active”, in that it has a powerful role in constructing our shared, lived realities. Further, these realities are co-constructed (Gee, 2014) through language exchanges.

This relational element of discourse means that Gee’s (2014) description of the relationship between speaker and listener is vitally important in understanding how different realities can be constructed within the same space. The relationship between speaker and listener, and the intensions and understandings that different speakers will bring to different audiences (and that frame how the messages are received by the audience) mean that each sphere of interaction will form a new set of realities. This is important when we consider the different discourses that are present within (for example) communities of people with mental health problems, and the

discourses that are present between mental health services and people with mental health problems. In each of these interactive spheres (within the community of people with mental health problems, and between people with mental health problems and mental health services, all within the context of a broader social, political and historical context) there will be different discourses constructed – indeed, different social realities. Each of these social realities comes with its own set of “rules”, and individual actors will have different identities and different roles to play within that set of rules.

Discourse forms identities of and for people within a social, political and historical context (Gee, 2014). Identities can be formed by people or groups for themselves, and they can be used by those in power to impose identities onto others. It is in this latter scenario that this study is particularly interested.

Discourse constitutes who we are, and the roles we are able to fulfil, based on traits we hold, and constrains ones roles in society based on traits one holds (Gibbs, 2015). Who we are, as constructed by discourse, is in relation to others (and/or society as a monolithic construct) (Gee, 2014a.). A group or individual can be discursively allocated a role in the mainstream, or can be allocated to the margins (Goodin, 2003). Identities are often formulated as relative. That is, how one is defined is often in relation to how one views ones relationships with others. Individuals are allocated a number of identities however, some of which are mainstream and some of which are not. This can be described as “intersectional identities” (Williams et al., 2019). Intersectionality is an important concept which allows us to appreciate that some discursive identities are marginalized and some are not, and both can co-exist in the same space, and even within the same person (Williams et al., 2019). This means discursively formed identities are fluid. They exist in the relational sense. This means they depend on social dynamics in moments in time, and on the relationships and interactions that occur in those given moments.

3.4 Methodology

3.4.1 Ontological and Epistemological Stances

The understanding of discourses and discursively mediated social reality, alongside the post-structuralism related to Foucault's work, provide the framework for the ontological and epistemological stances taken in this thesis.

This thesis takes a Foucauldian approach to discourse analysis. Foucauldian discourse analysis can be said to be post-structuralist (as described above). Foucauldian discourse analysis can also be described as constructionist as it is based on the meaning of social actions, practices and text with a particular focus on power and power relationships (Khan & MacEachen, 2021).

The ontological stance taken is that reality as it is experienced by humans is inextricably embedded in social relationships and is discursively mediated. While appreciating that there may be objective realities underlying social structures, it is accepted that such realities are generally inaccessible to individual understanding. So whilst this thesis does not reject the existence of objective reality underlying human experiences, it is based on the stance that our social experiences and our lived realities are constructed through our interactions with one another rather than with a direct relationship with objectively measurable phenomena.

This therefore provides the epistemological position of the thesis. The social interactions that construct our social realities are mediated through discourse and can be observed through the analysis of social interactions, and specifically can be measured through analysis of text. Knowledge, as such, is subjective. It is influenced by my own personal beliefs, experiences, and biases. While attempting to analyse data in as neutral a manner as possible, I acknowledge that research is discursively influenced, as is social reality. This is consistent with social constructionism. (Berger & Luckmann, 1991; Khan & MacEachen, 2021). Social constructionists do accept the existence of an objective reality (Andrews, 2012), and are primarily concerned with how

knowledge is constructed and mediated. Social constructionism, as is used here, makes no direct claims about objective reality, but simply refers to how people come to know and experience their social realities (Flaskas, 1995).

3.4.2 Methodological Frameworks

Social, historical and political power dynamics constitute the experiences of people with mental health problems, and as we have seen in the previous chapter, often form the basis of their relationships with others. These dynamics exist throughout society and its institutions. Mental health service services are embedded at the nexus of a variety of institutions – medicine, nursing, social work, police services – and legislated at all levels of government. Simultaneously, public attitudes towards people with mental health problems are entrenched with misperceptions, stigma and bias. These institutional, governmental, and societal norms and attitudes influence one another. The study of the language that is used to describe these norms, attitudes, identities can inform an understanding of the power structures that underlie the constructed identities and roles of people with severe and enduring mental illness, especially as these identities and roles related to experiences of abuse and exploitation.

This study used Critical Discourse Analysis (esp. Fairclough, 2003; Fairclough & Wodak, 1997; Wodak & Meyer, 2009; Gee, 2014a, 2014b) to trace these discourses, their origins and the ways they change and are employed between levels of government, medical and allied institutions, and broader society. The study of these discourses provides insights into how behaviours associated with non-criminal exploitation are perceived, and how people with enduring mental illness are perceived in ways that allow others to permit their exploitation. These discourses also provide insights into the ways that texts contain competing narratives at different levels.

3.4.3 Discourse Analysis

DA has seen widening acceptance in health research (Starks & Brown Trinidad, 2007). Its core assumption is that meanings and roles are

constructed, negotiated, and understood through use of language (Fairclough, 2003). Values, beliefs and knowledge are also socially constructed (Mason & Clark, 2021; Gee, 2014), and moreover, are co-constructed through interactions with others (Gee, 2014). The study of the use of language as representative of discursively constituted meaning is the heart of discourse analysis.

DA is useful for understanding the construction and communication of roles and relationships between individuals and communities. It has the potential to reveal insights into social and political contexts in which varied and conflicting discourses about health take place (Yazdannik et al., 2017).

Discourse analysis is used when researchers are especially concerned with how power is constituted, the power relationships that govern roles in society, with how discourses are either marginalized or privileged, and how they serve to exercise and protect power (Jager & Maier, 2009). This means research is focused on institutionalized patterns of knowledge and power, and how those are enforced (Yazdannik et al., 2017). It centralizes the notion that power and ideology provide “legitimation for relations of inequality and domination” (O’Regan & Betzel, 2016, p. 2). This has relevance to how persons with mental health problems relate to broader society and how that impacts issues related to their rights and to abuses of them. DA is concerned with social and political issues. Human rights are by nature political and about the distribution of power and responsibilities within society.

As with many methodological approaches, there are a variety of schools within discourse analysis. As this study is chiefly concerned with power dynamics, social, historical, and political influences on the lived experiences of people with mental health problems, a Critical Discourse Analysis [CDA] approach is appropriate.

3.4.4 Critical Discourse Analysis

While critical discourse analysis (CDA) is not often used in nursing research it has features that make it a promising methodology for health policy

research (Evans-Agnew et al., 2016). In this context is it used to analyse social practice and policy language to “examine whether such policies may promote or impede social transformation” (Evans-Agnew et al., 2016, p. 136).

Critical discourse analysis is an appropriate methodological approach to answer the research questions. As outlined previously in this subsection, the goals and assumptions underlying approaches to DA are consistent with the assumptions and goals of this study: Namely, that exploitation as a feature of vulnerability, and vulnerability is a feature of power relationships and marginalized community structures.

Critical discourse analysis [CDA] is understood and used here as a systematic assessment of the ways in which language is used, and the causal relationships between language-in-use, and broader social structures and attitudes. CDA is not focused on language per se but on the “linguistic character” of social processes and structures (Fairclough & Wodak, 1997). Some might argue, as Fairclough (1992) does, that some material social reality constrains discursively constructed realities, and that discursively constituted objects interact with those material realities (Fairclough, 1992). As such, language should be understood to be one of several layered elements that together formulate social realities. Examining language alone will not provide specific insights into discursively constructed reality, but rather examination of language should be done with reference to examinations of inter-related elements of power, belief, institutions, and so on (Harvey, 1996). Such examinations can reveal relationships of causal factors and effects (Fairclough, 1992) within broader social and institutional cultures. As Fairclough (1995, p. 135) describes it, CDA is used:

> *to systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power.*

This broader concern with critically examining inter-related elements of power and other social elements, through the study of language in use, is foundational to all forms of CDA. CDA - and this thesis – is focused on “ways social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context” and is “especially concerned with resisting social inequality” (van Dijk, 2001, p. 352).

CDA is both a theoretical stance and a methodological approach. It is used to illuminate the way language is utilized in social, historical and political contexts, and it is used to critically examine the purposes and the effects the use of language has, especially those effects that are marginalizing or oppressive. CDA is inherently concerned with power. The use of CDA in this thesis is intended to reveal the discourses that are present within the policies that dictate mental health practice in Scotland, assuming that these discourses are reflective of broader societal practices and attitudes.

Critical discourse analysis has roots in linguistic studies, and is primarily concerned with how power is constituted and transmitted through society via use of language (Wodak, 2002). Issues such as ideology, power, and hierarchy, as well as sociological variables, are appropriate for study via interpretation of texts (Wodak, 2002). As noted, CDA is especially interested in the relationships between language and power (Wodak, 2002) which is the primary reason it is used in this study. Critical discourse analysis, broadly speaking, is used to examine the ways social power, abuse, dominance, and inequality manifest in social and political contexts (van Dijk, 2009). CDA is concerned with social problems, power-in-discourse and power over discourse (Jenner et al., 2000).

CDA is adaptable and can be tooled for small studies as well as large (Tenorio, 2011; Wodak, 2002). CDA is also not limited to a single approach or methodology, and indeed is designed and evolved to be derived from a variety of theoretical backgrounds and orientations (Wodak, 2002). Again, this feature of CDA makes it appropriate for this study, which has roots in a variety of disciplinary fields, as outlined in Chapter 2. Some researchers state

that this heterogeneity in fact means that CDA is at most a loose association of approaches, or perhaps a shared perspective (Van Dijk, 1993).

Discourse, simply stated, is the use of language for communication. Discourse analysis seeks, in the simplest of terms, to analyse and understand the language used to communicate ideas, as well as the effects it has. Through the "critical" element of CDA, imbalances in political and social power that emerge from the effects of discourses are highlighted (Blommaert & Bucean, 2000). Further, in using a Foucauldian inspired approach to CDA, researchers reject neutrality in analysis, but rather aim to directly challenge these power inequities and their harmful effects (Jäger & Maier, 2009). In this way, the research become inherently political. For this thesis, CDA was utilized to examine the conceptual assumptions embedded in mental health service policy; and to compare and contrast these concepts and effects with the stated goals of these same policies. An underlying assumption is that the texts examined are reflective of – and shape - discursive practices embedded in broader social contexts and institutions.

3.4.5 Foucauldian/Critical Discourse Analysis

Critical discourse analysis is a heterogenous field (Tenorio, 2011), and there is a great deal of variability in the approaches, theories and methods that are used under the label of critical discourse analysis (Tenorio, 2011; Wodak, 2002). Thus it is necessary to further define the parameters of the framework I will be using, and the theories I will be guided by.

This project is strongly informed by the principles of Foucauldian discourse analysis. Some may define this as "Foucauldian DA" (Gibbs, 2015), Foucauldian critical discourse analysis (Jager & Meier, 2009), or the "Duisburg School" (Wodak, 2002). Regardless of the naming of it, this school of Critical discourse analysis adheres to Foucauldian understandings of social structures and asserts that "discourses express societal power relations, which in turn are impacted by discourses" (Wodak, 2002, p. 21). A critical component of Foucauldian critical discourse analysis is the

understanding that discourses are historically embedded, and that the historical context of a discourse must be understood to fully engage with critiquing it. This form of CDA is concerned with larger scale discursive events, examination of power discourses, and the historical, social and political contexts of discourses in action (Gibbs, 2015). This study is explicitly oriented with the principles of power in action, and is concerned with how identities are constituted through use of discourse (Tenorio, 2011). Thus it is appropriate to align this study with Foucauldian analysis.

Foucault's concern with the discourses embedded within mental illness care inspired his earliest work (Foucault, 1965). Foucauldian DA is concerned with power embedded relations and how people direct one another through scientific claims to legitimacy (Iliopoulos, 2012). These discourses are what lie at the heart of modern structures of mental health services. To disrupt these structures, other voices must be introduced and used in the production of knowledge and truth about experiences of mental health problems and distress (Swerdfager, 2017; Iliopoulos, 2012). Iliopoulos (2012) argues that Foucault's work offers a framework for rearticulating truth in psychiatry: there are no "marginalized discourses" that do not belong to the official discourse. We should not be privileging one form of "knowledge" over another.

This Foucauldian framework therefore provides the political stance from which this study is taken. It entails an explicit attempt to disrupt standing, discursively constructed power inequities that privilege both service providers and non-mentally ill members of society over those with mental health problems, and especially those with severe and enduring mental illness.

Thus, a Foucauldian understanding of Critical discourse analysis, as described by Jager & Meier (2009), forms the methodological basis of the study. The focus of Foucauldian CDA is on larger scale discourses, with an explicit focus on power and politics (Gibbs, 2015), and on how people are positioned within society and groups. Researchers using a Foucauldian CDA approach take a specific critical stance to undermine oppressive discourses (Gibbs, 2015). Using Foucauldian CDA approach is then appropriate to

meeting a goal of influencing policy to disrupt the current discourses that allow exploitation of people with mental health problems.

The central questions of concern in a Foucauldian CDA are: “What is valid knowledge at a certain place and a certain time; How does this knowledge arise and how is it passed on; What functions does it have for constituting subjects; What consequences does it have for the overall shaping and developments of society” (Jager & Maier, 2009, p. 191), where “knowledge” is understood to be any of the contents of consciousness and meanings people use to shape or interpret their environment (Jager & Maier, 2009).

To clarify, where it is stated that the thesis is influenced by Foucauldian principles, it is in specific reference to ideas related to medicalization of mental illness, the relationship between discourse and identity, and power relationships – rather than a broader adherence to Foucault’s stance on mental health problems and treatment.

3.4.6 Discourse-Historical Approach

Some argue that multiple analytic approaches to textual analysis assist in extracting and understanding the meaning of those texts (Hillier, 2004). It is in this spirit, that this study employs several analytic approaches at different stages, with the intention that the different approaches were appropriate for different stages of analysis, and that the different approaches were additive and enhanced overall understanding (Hillier, 2004).

Some elements of the Discourse-Historical Approach [DHA] as described by Wodak (2001) were used as a guiding framework for some aspects of the study. The methods described in the DHA approach provides a framework for tracing discourses across a variety of media, and thus is useful for this study. The explicit concern with producing concrete action (Reisigl, 2017) in the form of policy and practice recommendations also made this approach a good fit. These will be addressed in more detail further in the methods section below. At this point however, it should be understood that the DHA is generally understood to be a “multidimensional project incorporating theory,

method, methodology and empirically based research practices that yield concrete social applications" (Reisigl, 2017, p.48). It emphasizes a combination of observation, theory and method (Tenorio, 2011). As such, some may consider it to be a methodological approach as well as a prescribed method. Overall, the methodological philosophy of DHA are consistent with the Foucauldian CDA approach I have described above, especially in their mutual concern for and focus on interdiscursivity and for historical and social contextual analysis of discourses. Thus, for this study, I will continue to describe Foucauldian CDA as the methodological orientation, and the modified use of DHA as providing the structure and a framework for some aspects of analysis.

DHA approaches especially inform the data analysis of the archive, as described in Chapter 4. The principles of DHA are used to analyse the presence of intertextual discourses which is what made it particularly relevant for use in this study. Intertextual analysis is used to examine discourses that occur across a body of literature, wherein one can attempt to ascertain the origin of the discursive threads.

In Chapter 6 different types of DHA, as described by Reisigl (2011) are utilized in order to conduct an informed analysis of the discourses from a contextual perspective, and from a pragmatic, future-oriented perspective, respectively. These are the Sociodiagnostic critique and the Prospective critique.

3.4.6.1 Bacchi's Problematization in Health Policy

The final section of this project is focused on specific policy recommendations for the "problem" of non-criminal exploitation of people with mental health problems. This, as outlined in Chapter 7, is informed by Carol Bacchi's "Problematizations" in health policy (as described in Bacchi, 2009; 2016). Bacchi's What is the Problem Represented to Be? [WPR] approach is useful for conducting examinations of the values embedded within health policy. This post-structural and Foucauldian-influenced (Bacchi, 2016)

approach fits neatly within the influences of this project, and provides a useful framework for examining one's own policy directions.

3.5 Research Methods

3.5.1 Reflexivity & Positionality

3.5.1.1 In Social Constructionism

A central principle of the epistemological stance of this thesis is that meaning and knowledge are products of interaction (Khan & McEachen, 2021). This is inclusive of the gathering of knowledge in the form of research. Data analysis is conducted within the context of the researcher's situated experiences.

3.5.1.2 In Foucauldian CDA

As with Social Constructionism more broadly, in Foucauldian CDA the researcher must accept that she is embedded within the discourses she is studying – that any position taken is discursively constructed (Jager & Maier, 2009). It is also true that Foucauldian CDA researchers, as a goal of study, take a political position in relation to existing discourses, with the intent of disrupting oppressive discourses (Gibbs, 2015).

A feature that is unique to Foucauldian CDA, among other methods of Social Constructionism, is that Foucauldian CDA takes special interest and focus on the issues of power and social legitimacy (Khan & McEachen, 2021). Thus issues of power and legitimacy must be reflected upon as a factor in analysis.

To this end, I acknowledge my professional background as a Registered Psychiatric Nurse (the equivalent of a Mental Health Nurse in the UK), who has practiced in - and been empowered within - the medicalized mental health system as a clinician and as an educator of nurses. I have conversely been engaged in post-graduate study with emphasis on the study of ethics. As such, I am embedded in the discourses I am studying. This must be acknowledged not only as constructing the position I take in relation to the discourse, but is also useful for data analysis: As someone who is also embedded in these discourses, I have tools which enable me to interpret and understand the discourses (Gibbs, 2015; Jager & Maier, 2009). However, this

also has the potential to blind me to other discourses that may be present. This will require openness, constant acknowledgement of this limitation, and ongoing self-reflection on biases and assumptions, consistent with the process of bracketing in other forms of qualitative research (Fischer, 2009).

The political stance of this research is embedded in the acceptance of human rights as the centre of a moral system of mental health services. It is also found in the underlying assumption that current discourses constitute serious power imbalances and as such are oppressive to persons with severe and enduring mental illness. To disrupt this, the system must be redesigned with an aim toward de-centralizing power away from psychiatry/mental health service providers and towards persons with lived experience of mental health problems.

3.5.2 Data Collection: Samples

CDA analysis is focused on larger scale discourses. Anything that can be used to convey meaning is discursive. As such, while other forms of discourse analysis focus on texts and language-in-use, in Foucauldian CDA, data can include speech and text, but also visual media, images, art, video, icons, advertisements, etc. (Gibbs, 2015). Textual analysis of the data is not on minutiae of grammar and syntax, but on social, political, and historical trends that are expressed via the media used. These “texts” or discourses are seen to be social/political actions (Fairclough, 2003).

The first stage of data sampling was an exploratory mapping exercise. This means I dedicated time to the discovery of the “universe” of data available. From this “map of the universe” of possible data, parameters were drawn to focus the data within the Scottish context, and representative samples were then taken.

The following data sources were initially identified as potentially relevant to the research study. This list was expanded as part of the ongoing “mapping” process. From the expanded list, representative data were selected for analysis in an iterative process:

- Formal documents such as human rights codes and agreements, mental health acts and institutional policies

- Documents that service providers use to communicate to service users: specifically around their rights: e.g. pamphlets on admission; webpages; posters

- Media in which service users communicate with one another: for example, message boards on the internet, twitter discussions, self-advocacy websites and groups

- Data that can capture the voices and experience of persons, such as interviews with service providers, and narratives or memoirs that are produced by people with mental health problems.

- Third party sources, such as anti-stigma media campaigns by private groups

Data are clustered in three categories: Macro, meso and micro level discourses. Examples of these data sources were initially defined thusly:

Macro Data

- Human rights frameworks and directions, as well as the resulting legal structures that impact Scottish law and soft law

- Scottish laws (e.g. Mental health act of Scotland, 2015; Adult support and protection (Scotland) act, 2007).

- Scotland health and mental health strategies

Meso Data

- Institutional Policies

- Professional codes of ethics and practice guidelines

Micro Data

- Pamphlets/Posters on patient rights
- NHS or non-profit service websites
- Web board discussions/forums

3.5.3 Data Collection Process: Documentary Archive

The sum of available documentary data forms the so-called archive, defined as “the diverse collection of materials that enable you to engage with and think about the specific research problem or questions” (Rapley, 2011, p. 10). Developing this archive in a robust manner is the first step of discourse analysis. (Rapley & Flick, 2011). This is consistent with the methods associated with the first stage of Foucauldian discourse analysis is finding “textual examplars”, or documents that can represent the diverse collection of materials (Stevenson, 2004) and Critical Discourse Analysis (Janks, 1997). It is also consistent with the approach outlined by Wodak & Meyer (2009).

As such, the first step in data collection was to determine the parameters of the issue. This step is the “data mapping” exercise and is discussed in greater detail in Chapter 4. The parameters of the issue in this stage were determined by my research questions, aims and objectives. Dissecting those, the following were chosen as broad search parameters that defined the boundaries of my potential archive (guided again by Rapley & Flick, 2011):

o I was concerned with adults with severe and enduring mental illness, who receive mental health services in Scotland. Specifically I am concerned with persons who meet this criteria and are vulnerable to non-criminal exploitation by others.

o I was concerned with the current status and future directions of mental health service in Scotland. As such, all discourses in the archive should be ones that currently impact the state of mental health service in Scotland, or reflect the current state of mental health service in Scotland, or the potential future direction of mental health service in Scotland.

o Mental health service in Scotland, as it currently stands and as outlined in the strategy for future development, is explicitly focused on human-rights based care. As such, documents should reflect the human rights of people with severe and enduring mental illness either directly or indirectly.

o My research questions are specifically focused on abuse and exploitation. Documents then that involve exploitation and mental illness and direct or indirect references to human rights are considered.

From the data sources identified in the initial mapping exercise, representative cases formed the data sample for this study. The strategy for case selection emphasized variation (Palinkas et al., 2015), to discover themes that cut across various modes of discourse. Consistent with this, and for validity testing (further below), confirming and disconfirming cases were sought out in later stages of data collection (Palinkas et al., 2015). That is to say, cases that are consistent with themes as well as deviant cases (Stevenson, 2004), which run counter to the themes, were actively sought out.

Macro Level Data:

The Scottish mental health strategy (2017) was used at the initial textual exemplar. I chose this as it most clearly and thoroughly outlines mental health service policy directions, with a clear emphasis on human rights. Most importantly, this document presumably encapsulates future health service policies and practice directions in Scotland. It also has as reference point the current state of practice.

Focusing on the “human rights” discourse, I worked backwards to find the source document from which all human Rights-Autonomy Discourses seem to emerge. In this case, it was the European Convention on Human Rights (1950). Working backwards entailed reviewing the Strategy for reference to “human rights”. These references led directly to citations of Scottish laws

(esp. Actions 32-4). Review of the laws cited (as well as their descriptors provided by the government of Scotland, led directly to references to the Declaration.

I then searched for all laws I could find that were a) Relevant to Scotland and b) relevant to mental health or vulnerable persons or persons with incapacity and b) directly or indirectly cited the Declaration of Human Rights or Human Rights. Note that I include vulnerable persons here, because my working definition of exploitation and mental health problems requires an understanding of severe and enduring mental illness as a vulnerability. Persons with incapacity was included as it was referenced directly in the Strategy and was also relevant to my population of research concern. (Being adults with severe and enduring mental illness).

This search was conducted by using internet search engines. (e.g. googling “Scottish laws mental health”). Several laws were found directly in this way. In this manner, I also found a data base of UK laws, which I searched in a similar manner: http://www.legislation.gov.uk/. This data collected is in addition to the laws directly cited in the Strategy.

From there, I began to search for National (Scottish) health service policy direction documents that are a) relevant to mental health and b) directly or indirectly cite the declaration of human rights or human rights. (Search criteria). This search followed the same process, in that I used internet search devices using my search criteria.

I believed I reached a point of saturation (in this case meaning I have uncovered most of the archive that specifically meets my search criteria) when the documents became almost fully self-referential. That is, none of the new documents I was reviewing were referencing any unfamiliar documents. Though, I acknowledge that uncovering the full potential archive is not possible or practical given the scope of this project.

Note that Tables 4.2, 4.3, and 4.4 in the following chapter outline the archival data collected and reviewed for this study.

Meso Level Data

Meso level data has been defined for this project as texts that provide guidance at the institutional or professional level. This include policies, policy guidance documents, codes of ethics, practice guidelines, and so on. These texts are the link between the broader texts that form the macro level, and the texts that capture individual experiences (micro level). They represent the relationship between providers of care, people with mental health problems, and the general public.

The search parameters were similar as for the macro level: I searched for documents that contained references to mental illness and exploitation or abuse. I searched for these documents using two broad methods: first was a broad internet search of documents that met the criteria for: policy and mental health. The second broad strategy used was to search for documents that came from professional bodies I know from experience and research generally directly and frequently interact with persons with severe and enduring mental illness, and these interactions generally occur as a direct result of the mental illness. These criteria led me to search specifically for documents related to the following professions: Physicians, Nursing (especially Mental Health Nursing), Social Work, and Police.

For these specific professions, I searched for policy directions, practice guidelines, and codes of ethics. I especially searched for policy directions and practice guidelines around interactions with people with mental health problems, and for guidelines around reporting witnessed or suspected abuse. To search for these documents, I relied on the websites maintained by the relevant professional bodies. As this was a more targeted search, the point of saturation is reached when I was satisfied that I had captured a thorough range of documents from the institutions that I defined in the earlier stages of my research as being relevant to my research questions. The documents

effectively represent the formal practice directions provided to individual professionals.

Micro Level Data

The “micro” level is defined for this project as the individual experience. I searched specifically for texts that captured discourses as delivered to, received by, or interpreted by individuals.

Prior to commencing searching for data, the following textual exemplars were identified as good sources of micro-level data

- Pamphlets, especially those discussing the rights of persons with mental health problems
- Websites that might be accessed by persons with severe and enduring mental illness
- Books or poems written by persons with lived experience

To ensure websites accurately reflected which discourses a Scottish patient may likely encounter, I ensured to search using Google (as the most common search engine), from a Scottish IP address, using phrases such as “mental illness abuse”, “mental illness being taken advantage of”, “mental illness rights”, “mental illness exploitation” and so on. I generally searched for “abuse” over “exploitation” as this would be more commonly used language. I then filtered findings based on my defined definition of exploitation. I also searched specifically for Mental Health Advocacy organizations, and searched their websites for materials that would be available to patients. Similarly, I searched NHS mental health websites for texts related to patient rights, and abuse.

As I conducted this search, I became aware that I would need to do a double pronged approach to searching micro-level data. On one hand, I was finding many texts that would communicate information to persons with mental illness. On the other hand, I was also finding, and became aware of the

importance of, texts that communicated the received messages or situated meaning (Gee, 2014) of the discourses. As a result of this realization, I divided the micro level texts into 2 broad categories (one of which became subdivided):

- First, was the category that captured messages to persons with mental health problems. This category is subdivided into a) formal messages from institutions (e.g. posters, pamphlets, websites from the NHS) and b) "informal" messages from sources such as media (e.g. news articles) which more broadly captured societal attitudes related to the research questions. These messages, in discourse analysis terms, are those that describe to people what their subject positions are/can be. (Gibbs, 2015) The texts capture the subject positions of persons with mental health problems relative to the society in which they live. They also capture the subject positions of potential exploiters. (On this latter point I realized it would be valuable to capture an understanding of discourses that would allow "normal" members of society to target people with mental health problems for exploitation).

- The Second category is texts that directly capture lived experience. This includes for example posts to online message boards, poetry, etc.

- For both categories, I also came to realize a powerful example of texts included media. As such, I have collected a number of examples of media, which covey messages both to and about persons with lived experience of mental health problems.

Pragmatically speaking, it would be impossible to reach data saturation per se at this level. My aim was to gather a broad range of representative data, guided by my knowledge of mental health/illness, and by my previous research.

3.6 Data Analysis

Methods of data analysis varied between different phases of the study. As such, Chapters 4 and 5 contain more detail about the particulars of data

analysis in each of the two main phases. However, broadly speaking, CDA requires reading and re-reading of the texts, again and again. Text fragments (sentences, phrases, paragraphs, words, etc.) that seemed relevant were highlighted and categorized. These categories were refined and revisited as the analysis went on and further documents were read and discovered. Initially (as discussed in detail in Chapter 4) I searched the archive for information relevant to exploitation. As other themes emerged from the data, I expanded the search to include these other themes. The process also entailed continuous reflection on the meaning of these themes within the context of health care services and the social, historical and political environment in which these documents exist. It also entailed constant reflection on the impacts these textual fragments and themes would have on the discursively constructed identities, and the experiences of people with mental health problems and health service providers. Ongoing discussion with the thesis supervisors helped to clarify and stimulate this reflection.

3.6.1 Theoretical Frameworks

Data mapping, sampling and analysis is an iterative process. It is appropriate, in CDA, to continue to seek out relevant related data sources as analysis is taking place (Stevenson, 2004). This helps to confirm, dispute, or clarify themes as they are being formed. As such, as analysis is occurring, other data sources became relevant to the research and were added. Similarly, it transpired that some identified forms of data became irrelevant or superfluous, and as such were removed.

The Discourse Historical Approach [DHA] framework (Wodak, 2001) is appropriate for assessment of the macro, meso and micro dimensions, and allows for unique analysis of each dimension. It requires that the socio-historical factors of the text are considered, which will allow for analysis of the apparently competing socio-historical discourses identified to date. In the interconnections of analysis, the researcher finds patterns and disjunctions that are to be described, interpreted and explained (Janks, 2006). Each text is analysed separately, and further related texts are analysed to confirm,

affirm, or further develop explanatory hypotheses developed from the initial analysis.

During textual analysis, it is necessary to explore the different audiences that are meant to receive the message, and the meaning that they will ascribe to the message based on the discourses or subject position, that they inhabit. This is described by James Gee (2014) as the “situated meaning” of the text. There are a variety of approaches to data analysis in CDA (O’Regan & Betzel, 2016). Most approaches, however, encompass the following stages (from Parker, 1992 via Gibbs (2015): 1) Subjects and Objects (in which the macro level discursive resources are identified, namely the identification of topics and themes are being used); 2. Identification of the relationships between discourses, including supportive or contradictory uses 3. Action Orientation (in which one analyses the function the discourse/text is serving; which institutions are represented; how is responsibility attributed). 4. Positioning (in which the researchers assess the subject positions available in the discourses) and finally an assessment of 5. Discourse and Power (in which the power relations supported and reproduced by the text are assessed – this especially is where the researchers political stance is needed, such that “desirable” or “oppressive” discourses can be evaluated as such). In this particular study, each of these stages is conducted in both stages (as described in Chapters 4 and 5).

Using the DHA approach as a guiding framework, data analysis was conducted beginning with the selected exemplar documents at each level. Analysis of each of the selected examplar documents occurred in 3 stages: 1. Analysis of the individual documents for contents/topics (i.e. discourse themes); 2. Investigation of the discursive strategies employed in the texts and 3. Analysis of the context of the texts (Wodak & Meyer, 2009). The analysis will be described in detail in Chapter 4.

After the analysis of individual documents, the relationships between the exemplar documents at each level (macro/meso/micro) were analysed. From here, further analysis between documents within and between levels was

conducted, with a focus 'interdiscursivity' (Wodak & Meyer, 2009) - or, roughly, how the discourses are transmitted and altered, and how they are deployed, between the different levels.

The final stage of this data analysis was to scan the remainder of the archive for confirming and disconfirming cases. That is, examining the archive for examples of how these same discourses occur throughout, and cases where these discourses are directly contradicted by other discourses, or where those discourses simply do not seem to have influence.

3.6.2 Analysis of Textual Archive and Representative Documents (Chapter 4)

The processes used will be described in greater detail in Chapter 4. An archive of documents was collected as described above in section 3.3.5. Explicitly looking at the entirety of the data available, texts related to the problem of abuse and exploitation were gathered. From this set of texts, documents were carefully read and re-read for relevance to the aims and objectives of the study. Documents that proved irrelevant or only marginally relevant were set aside and not included in the archive. I organized this initial collection of documents across three levels which I labelled macro, meso, and micro (as described above).

It is important to note at this point that the first review of data included an extremely large number of documents, many of which are used for contextual information further in this analysis, and many of which were rejected as not containing immediately relevant information (however likely informed my knowledge of the overall archive and its contents). Many of the documents that were reviewed and are used for contextual information further in this analysis are documents and factsheets from the United Nations and the World Health Organisation. Where these documents provided relevant information, their references can be found in the reference section.

Texts of interest in the initial data set were organized by macro, meso and micro level. As described above, documents were collected in three

"clusters", roughly organized by their level of authority. Some of these documents were selected for further review, and some were eventually not utilized.

Initial observations regarding the documents were recorded (as described in Chapter 4). Using these observations, a representative set of 10 documents were selected for more detailed analysis. The methods used on this stage of research were guided by the Discourse-Historic Approach [DHA], as first described by Wodak (2001), and especially as outlined by Reisigl (2017).

The DHA approach was selected for this stage as it allows for discourse fragments to be assessed across a number of documents (rather than focusing on singular documents). Utilizing the DHA, thematically and functionally similar discourse fragments are identified and assessed for inter-connectiveness (Reisigl, 2017). It is especially important that the discourse fragments are selected within a specific period in time (Reisigl, 2017). This allows one to meaningfully determine the existence of relationships between the discourse fragments. From this, one can build a case for the relationships between discourse elements from a "bird's eye" perspective, taking into consideration the larger whole and the interconnections between discourses that form a larger macro-discourse. The texts that were chosen from the archive were contemporary: They, at the time of this writing, are currently active documents and represent the current state, and the current context, of mental health services in Scotland.

To the representative documents the following steps were taken: 1. Identify the topics and texts of a specific discourse; 2. Investigate discursive strategies; and 3. Examine linguistic means (types) and "context dependent realizations" (tokens) (Reisigl, 2017).

Identification of the topics and texts of the discourses was informed by the process of the literature review and through the process of collating the documentary archive. As the literature review was conducted, and the documentary archive was collected, I remained actively engaged with

reading the texts and identifying themes that emerged and seemed apparent throughout the different texts. As I collected documents and articles, I highlighted discourse fragments that were relevant to my research and began to organize them into topics. Topics of potential interest were identified prior to reading through the documentary archive. This step occurred during the process of formulating the research question and the searching and gathering of the archive. As the overall archive was collected and reviewed, topics that were initially identified were expanded upon and refined. Throughout the first read-through of the archive, other topics were revealed. As this occurred, I set aside for more detailed analysis the texts that contained the topics and discourses I was tracking. The topics that emerged from this process were: vulnerability, abuse, exploitation, human rights, mental illness/health/ill health, mental disability or mental disorder.

For the second and third steps of the process (investigating strategies and the types and tokens of the texts), each of the representative texts were analysed individually to understand discursive strategies utilized, and the topics present. Discursive strategies were assessed by asking such questions as (adapted from Wodak, 2001): “How are persons, objects, phenomena, events, processes and actions named and referred to linguistically?; What characteristics or qualities are attributed to social actors and phenomena?; From what perspectives are these expressed?; Are these expressed overtly? Tacitly? Do they intensify or mitigate?” (p. 10)

This occurred alongside more detailed examination of the topics that were present. Topics, and their sub-topics, are the building blocks of the discourses. Topics can be examined by describing the types and tokens that are embedded with in a text. Types and tokens are related but ontologically distinct concepts (Busquets, 2007; Wetzel, 2018): Types can be understood as the patterns that are produced by the tokens, which are the actual “semiotic units” (Reisigl, 2017). That is, tokens are the statements, sentences, phrases, and so on, that are produced, distributed, and received by people via the text in question.

The topics that exist within each text were described, in order to trace which topics overlap and form larger pattern. In this process, I also consciously focused on the presence of roles and identities that are prescribed by the texts. Using these steps, themes that were consistent across the documents were uncovered. These themes were further organized, eventually, into inter-textual discourses. That is, discourses that exist and are similar across different forms of text. In this case, discourses that are present in some form or other in most texts selected for analysis.

3.6.3 Focused Data Analysis (Chapter 5)

As will be discussed in more detail in upcoming Chapters, from the archival analysis it seemed it would be appropriate to conduct a focused analysis on the Mental Health Strategy of Scotland 2017-2027. For the analysis of the Strategy it became more appropriate to utilize a different framework than was used in the previous analysis. This is due to the nature of DHA being largely appropriate for larger archives of text. To analyse the Strategy, a more focused method was appropriate. The strategy analysed in detail to gain insights into how abuse and exploitation may be addressed, and to analyse the document overall to gain an understanding of how in general people with mental health problems are framed as recipients of service. In a general sense, the document was analysed for how people with mental health problems are “talked about” – what role in society are they “allowed”. As such, given its focus on power, authority, and discursively constructed relationships, I used the analytic questions described by Rapley (2011) as the analytic framework.

For the first pass of analysis, guiding questions (Rapley, 2011) used were: What authority does the Strategy appeal to, for example by the citations the text uses; What source of knowledge and evidence does it cite; What are the authoritative sources of knowledge it references; Who are the experts as presented; How are subjects – e.g. patients – referenced; What value judgments may be embedded in choice of language?;What relevant voices are not drawn on in this text?; What is the defined “problem” in the text; Who

is presenting the “solution” to the problem; and how are specific identities produced, sustained and/or negotiated within texts? (Rapley, 2011).

The reasoning used in this stage of analysis is best described as abductive, as conclusions are drawn from partially known information. That is, none of the previous information is definitely proved, but the conclusions are arguably the best explanation for the observed phenomenon based on what is known and other conclusions reached.

3.7 Methods Schematic

The methods used in this thesis are diagrammatically represented in this figure. As described, the initial research concept guided the literature review. The gaps in the literature and the major issues revealed by literature, in combination with the initial concepts, led to the development of the research questions. These questions, informed by the major themes of vulnerability, marginality, and power relations in the literature, led to the selection of critical discourse analysis as the guiding methodology.

The research is divided into several major stages. First, is a review of the documentary archive, which was guided by the Discourse-Historical approach. This analysis led to the identification of major inter-textual discursive themes.

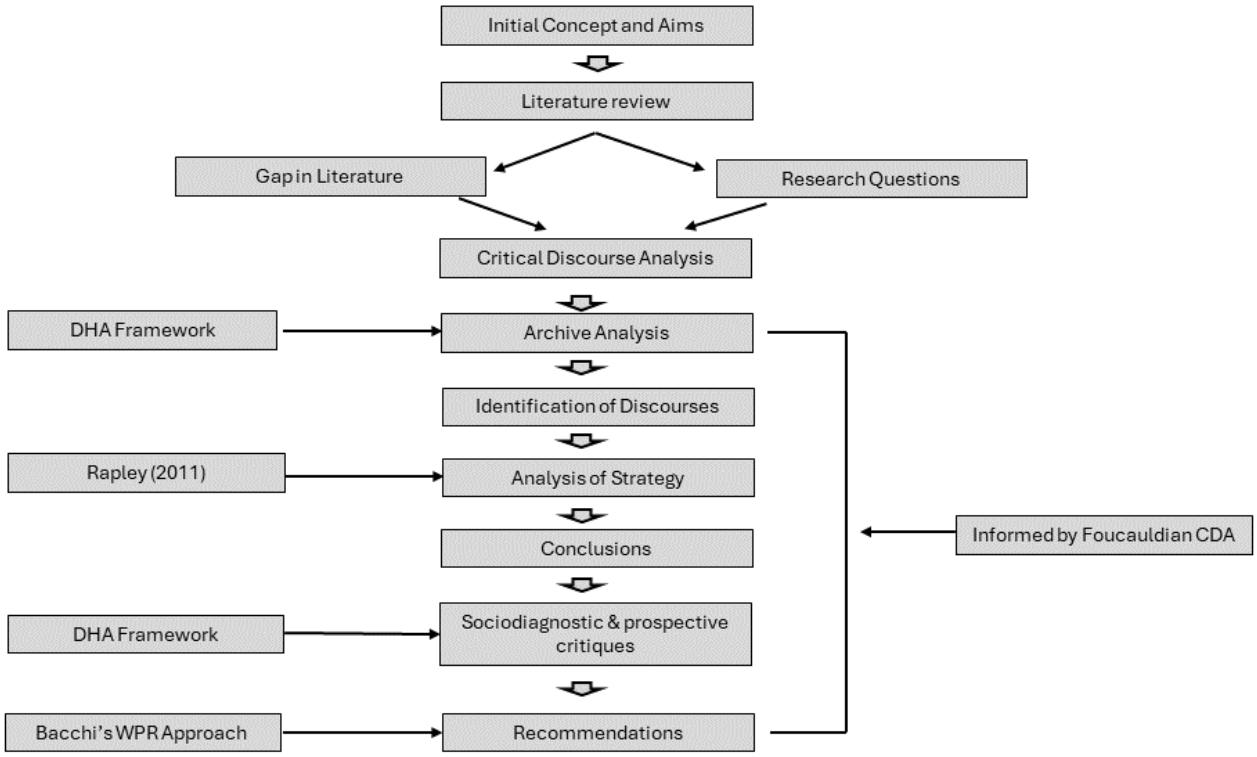
The next stage of analysis focused specifically on Scotland’s mental health strategy. This stage was two-fold. First, an independent review using the framework described by Rapley (2011) uncovered a variety of different meanings in the text. In a second stage of analysis, the discourses uncovered from the archival analysis are mapped onto the strategy.

Following this, conclusions are reached from the analysis. These conclusions are used to inform the sociodiagnostic and prospective critiques, where again utilize a framework taken from the DHA.

Finally, recommendations for policy in mental health services are proposed. These recommendations are in part based on further analysis of issues utilizing Bacchi's WPR approach (which is described below).

All stages of analysis are informed and influenced by Foucauldian principles, or a Foucauldian approach to critical discourse analysis. That is, a primary concern with understanding the meaning of actions, practices and institutions, using a lens of power relations (Khan & MacEachen, 2021). Further, it is informed with legitimacy of social structures and how that legitimacy is transmitted via discourse (Iliopoulos, 2012).

Figure 3.1 Methods Schematic



When it became apparent that no single methodology would fully provide the answer to the research questions, I utilized a number of methodological frameworks in different phases of the study, and compared the results to form a conclusion based on the broader whole. I found that the different methods used were complementary and enhanced the understanding of the discourses.

The nature of this project required a flexible approach and one that allowed for larger numbers of documents to be assessed than is typical in a discourse analysis. The specific outcomes I was searching for did not fully fit any of the methodologies available. For example, while elements of DHA were helpful for data analysis, and for providing a framework for analyzing discursive themes *across* documents while respecting the relationships between documents and the time frames in which they were active, there were elements of DHA that were too rigidly focused on the historical aspects of documents. In the case of my study, I was focused on contemporaneous impact of the documents rather than a full understanding of the historical contexts in which they arose.

3.8 Rigour

While some argue that conventional understandings of validity and reliability are unworkable when applied to DA (Potter, 1996; Stevenson, 2004), there are ways to ensure rigor. Stevenson (2004) summarizes four steps that can be taken to allow confidence in DA research: deviant case analysis; participants' understanding; coherence; and readers evaluation. In this study, deviant case analysis; coherence and readers' evaluation are used.

Deviant case analysis While assessing patterns of occurrence of a discourse/text/phenomenon, it is equally important to attend to instances that do not track with the pattern. The researcher must be open to the possibility that deviant cases invalidate the original hypotheses or patterns detected (Stevenson, 2004). In Chapters 4 and 5, deviant cases are attended to and noted where they exist.

Coherence The researcher conducts a thorough literature search for studies of a similar nature/theme and assesses the degree of consistency or inconsistency of the findings with the body of literature (Stevenson, 2004). In this thesis, literature is a major source of information and is regularly referenced throughout for such consistencies. In analysis of the documentary archive and in the latter chapters that present critical evaluation, parallels with data that is available in the literature are drawn.

Readers' evaluation As previously mentioned, the researcher attends to their own contributions to the construction of discourses. The researcher may also use her own knowledge to provide understanding of the discourses, subject positions, meanings, and so on, under study (Stevenson, 2004). This is addressed in part in this Chapter in the section on reflexivity, in which my own background is addressed. The meaning I bring to the research is acknowledged and addressed.

One source of rigour in this study is the use of a number of methodologies to test similar concepts, for example, in Chapter 7, where a problematization of exploitation is presented utilizing Bacchi's WPR approach. Numerous methods that demonstrate similar results can help provide some degree of confirmation of results.

3.9 Limitations

Critical Discourse analysis as a theoretical framework and as a methodology are not immune to criticism. Most commonly, critics of the methodology argue that the theoretical foundations are somewhat confused, and that the use of concepts are often inconsistent (Tenorio, 2011). More broadly, it should be noted that post-structuralism has been criticized for being "idealist and apolitical", and lacking rigorous evaluative standards (Woodward et al., 2009). Further criticism of CDA focuses on the heterogeneity of the field. This criticism states that CDA is at most a loose association of approaches, or perhaps a shared perspective (Van Dijk, 1993). As such, it may be argued that it lacks coherence and rigour as a methodological approach. These

concerns are in part addressed by clearly lay out the theoretical foundations being used and the way they are being applied to the project.

Similar criticisms of these approaches focus on the inherent relativism of social constructivist approaches. A social constructionist approach does not attempt to reveal any ontological truths, but focuses on the complexities of human interactions in an attempt to find meaning (Khan & MacEachern, 2021). These interactions can be open to various interpretations. In fact, the researchers' own biases and preconceived notions will strongly influence data analysis. While I reflect on the biases I myself bring, through the role I play in mental health systems (see above in section 3.5.1), these biases and previous observations constitute a limitation of this study.

A limitation of the study is that it is narrowly focused on the interface of Western (specifically Scottish) mental health policy and a western/Scottish social and political milieu.

3.10 Chapter Conclusion

This Chapter has focused largely on the philosophical and theoretical orientations taken, and the justification for the use of critical discourse analysis. Due to the complicated nature of this study – namely the combination of a number of specific methodologies to answer the research questions, there will be further discussion of the actual methods taken in Chapters 4 and 5. This will allow for more clarity on the actual steps taken at various stages of analysis.

Chapter 4 Analysis of Textual Archive and Representative Documents

This chapter will outline how the initial collection of the textual archive was conducted, including how documents were selected and which documents were selected for further analysis. The chapter goes on to outline the details of analysis, including analysis of each of 10 selected 'representative' documents. The features that become the described discourses are highlighted in each document. From there, prominent themes that occur between and across the documents are identified.

The chapter then goes on to demonstrate the prominent discourses that occur *across* the selected documents. From here, the conclusion that there are two meta-discourses that are present across most documents is described and demonstrated, with the discourses named the "Harms-Paternalist" discourse and the "Rights-Autonomy" discourse. A preliminary discussion of the importance and possible implications of these discourses follows. Finally, the "formed identities" of people with mental health problems within this paradigm are described.

4.1 Data Collection & Analysis

The broad aim of analysis in this phase was to uncover the official narrative that is embedded within texts, and how that narrative defines the rights of people with mental health problems and their place in society and mental health service provision. A further aim was to gain insights into how this impacts their vulnerability to abuse and exploitation, as well as answer the question of what role service providers do and should play with regards to abuse and exploitation of people with mental health problems.

4.1.1 Collation of the Archive

An archive of documents was collected as described in Chapter 3. Explicitly looking at the entirety of the data available, texts related to the problem of abuse and exploitation were gathered. From this set of texts, documents were carefully read and re-read for relevance to the aims and objectives of

the study. Documents that proved irrelevant or only marginally relevant were set aside and not included in the archive. I organized this initial collection of documents across three levels which I labelled macro, meso, and micro (as described in Chapter 3): The Macro level was defined as any document that exists at the level of laws or above. Thus, it included all relevant laws, as well as government level strategies. It also included all international treaties and conventions to which the United Kingdom, and thus Scotland, were signatory. The Meso level were documents that translated these laws, treaties and strategies into policies, procedures, and guidelines. This level was conceived as the level of documents that brought laws, principles and standards into actual mental health service practice. The Micro level were documents that represented individual experiences or events or represented a way of communicating to individuals. (This final point in contrast to communicating to groups such as professional bodies).

Table 4.1 below provides the initial traits I used at the outset of the collection of documentary data. These traits were used to organize the data collected, with the intention of organizing them by how directly they interface with service providers and service users.

Table 4.1 Initial Organizational Themes of the Archive

Level	Document Traits	Examples
Macro	Documents that outline laws, conventions or treaties that guide law in Scotland	Scottish Laws (Mental Health Act, Adults with Incapacity Act (2000), Support and Protection of Adults at Risk Act (2007) et), UK laws that supercede Scottish laws (Human Rights Act). Scotland's mental health strategy and supporting documents. Human Rights documents that Scotland is signatory to, including the European Convention on Human Rights and various UN

		and WHO rights treaties and supporting documentation.
Meso	Documents outlining the standards and practice guidelines of the following professions.	Physicians (this includes all mandatory reporting guidelines and guidelines for assessing competence); nurses; social workers; and police. I especially focused on any documents that specifically address mental health/illness/disability
Micro	Documents that are provided to users of mental health services outlining their rights.	Pamphlets or online sources of information that target service users. Media describing mental health problems and abuses.

It is important to note at this point that the first review of data included an extremely large number of documents, many of which are used for contextual information further in this analysis, and many of which were rejected as not containing immediately relevant information (however likely informed my knowledge of the overall archive and its contents). Many of the documents that were reviewed and are used for contextual information further in this analysis are documents and factsheets from the United Nations and the World Health Organisation. Where these documents provided relevant information, their references can be found in the reference section.

This first review of data, during the phase of collating the data archive, led to a somewhat unexpected result (as outlined in Chapter 1): I anticipated not finding explicit mention of exploitation, given my own familiarity with professional guidelines in Canada. However, I did expect to find some guidance in the form of direction regarding abuses that could be deemed exploitative. There is provision for people with mental health problems to be protected from abuse and behaviours that could be construed as exploitative, especially in Adults with Incapacity Act (2000), Adult Support and Protection Act (2007), however both of those protect individuals who lack capacity due to mental health problems or who are unable to safeguard themselves due to

their mental disability. Thus their usefulness is constrained only to those instances. Outside of these acts, there are no direct provisions specifically identified for persons with mental health problems who are being abused and exploited, and in fact, in some documents, it explicitly appeals to individuals' right to autonomy in such circumstances.

4.1.2 Initial Data Sets of Interest

In the following tables (4.3, 4.3 and 4.4) texts of interest in the initial data set are described, organized by "macro", "meso" and "micro" level. As described in Chapter 3, documents were collected in three "clusters", roughly organized by their level of authority. Macro level data are documents that describe laws and legal obligations (such as international treaties), meso level documents describe policy and professional practice, and micro level documents are generally intended to be directly accessible to the general public. The relationship between the levels of data are further described below in Figure 4.1. As noted above, these tables do not contain the entirety of the documents I read and reviewed, but rather represent the documents that I set aside as having the most relevant content and/or the promise of being informative for the purpose of analysis. Some of these documents were selected for further review, and some were eventually not utilized. The selection of documents, where it may seem irrelevant to the future direction of study (such as the selection of news articles and lived experience texts), provides insight into the evolution of thinking regarding the research process and have been left here as an indication of such.

Table 4.2 Archive: Macro Data

Document	Author	Date
UN Universal Declaration of Human Rights	United Nations	1948
Right of everyone to the maximum attainable standard of health and mental health	United Nations	1948

UK Human Rights Act	Government of UK	1998
Scotland human rights law	Scottish human rights commission	2020
Mental Health Act of Scotland, 2015	Government of Scotland	2015
Adult support and protection act of Scotland, 2007	Government of Scotland	2007
Scotland mental health strategy	Government of Scotland	2017
Information on Mental Health Act of Scotland	Mental Welfare Commission of Scotland	2020
Right of everyone to the maximum attainable standard of health and mental health	United Nations Special Rapporteur	2019
The right to health	Office of the High Commission for Human Rights & World Health Organization	2008
Patient Rights Act (Scotland)	Government of Scotland	2011
European convention on human rights	European Court of Human Rights Council of Europe	1950 amend ed 2010
Disability Rights in the UK	Equality and Human rights commission	2020
Scottish Supplement Disability Rights in the UK	Scottish human rights commission/Equality and Human Rights commission	2017
Convention on the Rights of Persons with Disabilities	United Nations	2006

Table 4.3 Archive: Meso Data

Document	Author	Date
Standards of Proficiency for Registered Nurses	NMC	2018

Professional standards of practice and behaviour for nurses, midwives and nursing associates	NMC	2015
The Code of Ethics for Social Work	BASW	2012 (updated 2014)
Ethical Guidance	GMC	2020
Mental Capacity	GMC	2020
Adult Safeguarding	GMC	2020
Adult Safeguarding: Roles and Competencies for Health Care Staff	Intercollegiate	2018
Safeguarding adults at risk toolkit	Royal College of GPs	2017
Adult Safeguarding ethics toolkit	BMA	2017
Policing 2026 - A healthier Scotland	Police Scotland	2018
Policy Guidance Scotland		
Good mental health for all	NHS Health Scotland	2016
Mental health in Scotland	The Scottish Parliament	2014
Inequalities Briefing (Mental Health)	NHS Health Scotland	2017
Mental health inequality briefing	NHS Health Scotland	2017
Good Practice Guide: Supported Decision Making	Mental Welfare Commission for Scotland	2016
Disability Rights in Scotland	Scottish Human Rights Commissio	2017

	n/ Equality and Human Rights Commissio n	
Mental Health: Inequality Briefing	NHS	2017

Table 4.4 Archive: Micro Data

Document	Author	Date
NHS/Health Service		
Advocacy information	Care info Scotland	2020 (retrieved)
"Your rights"	Care info Scotland	2020 (retrieved)
Human rights in practice	Scotland Association for Mental Health	2020 (retrieved)
Your Rights	Scotland Association for Mental Health	2021 (retrieved)
The mental health act	Mental welfare commission Scotland	2020 (retrieved)
Mental health	Scottish human rights commission	2020 (retrieved)
Know your rights	Scottish association for mental health	2020 (retrieved)
Care, Support and Rights	NHS Inform	2020 (retrieved)

The United Nations Convention on the Rights of People with Disabilities: What does it mean for you?	Scottish Human Rights Commission/ Equality and Human Rights Commission	2010
Mental Health Advocacy & Human Rights: Your Guide	British Institute of Human Rights	2013
Lived Experience Texts		
Help Needed	From Mental Health Forum	2020 (retrieved)
A Disorder for Everyone in Words and Images	A disorder for everyone/Tom Bailey	2020 (retrieved)
Skydiving for Beginners	Jo McFarlane	2014
Janine Booth poetry	Janine Booth	2020 (retrieved)
Media (Not Specific To Scotland)		
Parents at risk of being drawn into crime	The Metro	5/4/2020
The Mad Issue	Vogue	Jul 2020

Note that in Table 4.4, many of the documents are online resources intended for consumption by the general public. As such, the date given is the date that the document was copied and printed from the internet. In each of these cases, there has been no notable changes to the documents at the time of this thesis being submitted.

Figure 4.1, below, illustrates the relationship between the different texts within the archive, and how the relationships were conceptualized at the outset of the data collection. At the uppermost level are the “macro level” documents. The Mental health strategy is informed and constrained by the

laws of the United Kingdom and the devolved laws of Scotland. Similarly, it is informed and constrained by human rights commitments that are external to normal legal channels, but nonetheless guide actions taken under the strategy. The mental health strategy directly influences policy of mental health services. at least in stated principle. Finally service users, at the “micro level” are influenced by the policies and professional guidelines used by those who provide services. The large circle represents society at large, the context in which the policies and guidelines exist and are enacted, and in which the service users live their lives. The circle partially encompasses the policy and guidelines boxes, as the service providers who enact these exist in the same social contextual sphere as the service users.

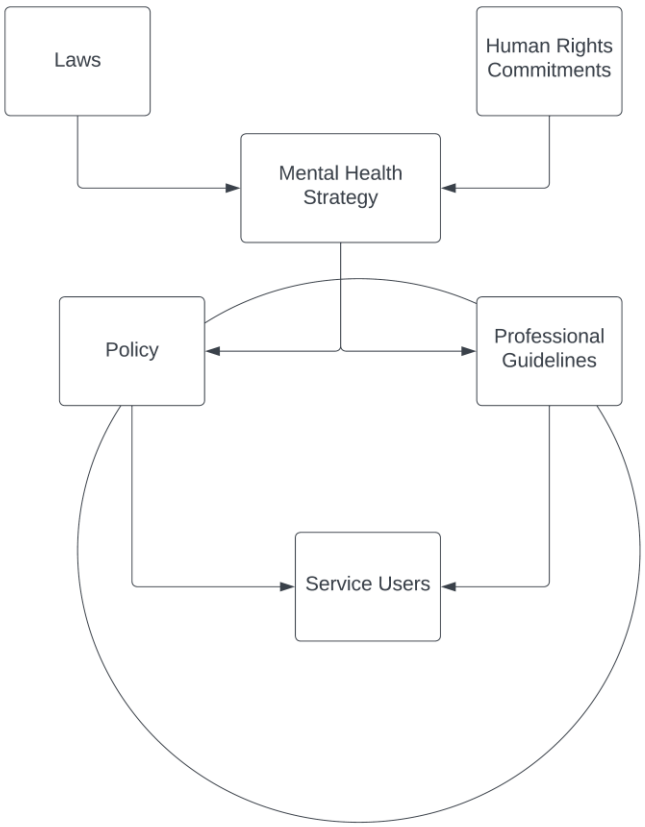


Figure 4.1 Relationship between the Documents

4.1.3 Initial Observations

During the collation of the documentary archive it became evident that on the specific issue of exploitation, the archive contained no explicit content. The

archive was almost entirely devoid of direct mention of exploitation, and at no point was any issue related to exploitation of persons with mental health problems articulated or described. In some instances, where the word "exploitation" did appear, it was not in relation to a concern for the exploitation or vulnerability to exploitation that might occur, with the exception of micro level documentation. For example, in the Adult Safeguarding Toolkit (British Medical Association, 2020) exploitation is described thusly:

> *The Care Act includes victims of modern slavery, domestic abuse and sexual exploitation. These are largely criminal matters and would require police involvement. (p.9)*

However, in the "Your Rights" (Scotland Association for Mental Health, 2021) document, it is described thus:

> *"People with mental health problems have the right to not suffer exploitation, violence and abuse". (para.1)*

This absence is notable due to the evidence in the literature that exploitation is a concern for marginalized persons. Below, in the descriptions of individual documents, I highlight the very few direct mentions of exploitation.

Even when expanding search criteria, to encompass broader concerns with abuse, there was a surprising lack of content discovered within the archive, especially when people with mental health problems were positioned as victims. Conversely, the archive had much to say about people with mental health problems as perpetrators of abuse.

Despite the complexity regarding defining exploitation (as discussed in Chapter 2), this was an unexpected finding. Interestingly, where abuse of people with mental health problems is present, it is in the context of unequivocal statements that persons with mental health problems are more vulnerable to abuse. For example:

> *Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization,*

> *and disregard of individual legal capacity to make decisions. (World Health Organization, 2017, para. 16)*

> *People with mental disorders are, or can be, particularly vulnerable to abuse and violation of rights. (World Health Organisation, 2020, para. 5.)*

Thus there appears to be a notable gap between what was being said of abuse, and what was being said *about* abuse. To explain: On one hand, it is acknowledged in strong language that individuals with mental health problems are vulnerable to forms of abusive treatment. On the other hand, there is generally very little said about how it should be addressed, or any details of the concern, beyond simple statements of the concern existing. The problem exists, per the documents, but there are no proposed solutions or actions, which is especially unexpected given the archive was collected with an eye towards any documents that would (if present) provide information on concrete policy or practice actions that could be taken by service providers to mitigate the risk of abuse.

This unusual set of circumstances – the absence in the texts of explicit mention of the phenomenon I sought to study – resulted in the analysis turning towards this very absence. What is the gap in the textual archive, why does it exist, and what are the implications for practice in mental health services in Scotland? To answer this question, I conducted a more detailed examination of 10 documents within the archive utilizing elements of the Discourse-Historic approach. This was done to provide further insights into key documents related to the provision of care of people with mental health problems in Scotland, especially around the provision of care to people who may be vulnerable to exploitation or abuse.

4.2 Data related to Abuse and Exploitation

This section describes the second stage of the analysis of documents, which followed the collection of the archive. Ten representative documents were selected from the archive for more detailed analysis (see Table 4.5). The

methodology used on this stage of research was the Discourse-Historic Approach [DHA], as described by Wodak (2001), and especially guided by Reisigl (2017). The DHA approach was selected for this stage as it allows for discourse fragments to be assessed across a number of documents (rather than focusing on singular documents). Utilizing the DHA, thematically and functionally similar discourse fragments are identified and assessed for inter-connectiveness (Reisigl, 2017). It is especially important that the discourse fragments are selected within a specific period in time (Reisigl, 2017). This allows one to meaningfully determine the existence of relationships between the discourse fragments. From this, one can build a case for the relationships between discourse elements from a “bird’s eye” perspective, taking into consideration the larger whole and the interconnections between discourses that form a larger macro-discourse. The texts that were chosen from the archive were contemporary: They, at the time of this writing, are currently active documents and represent the current state, and the current context, of mental health services in Scotland.

4.2.1 Process of Analysis

To the textual archive, I applied processes consistent with DHA. Namely the following steps were taken: 1. Identify the topics and texts of a specific discourse; 2. Investigate discursive strategies; and 3. Examine linguistic means (types) and “context dependent realizations” (tokens) (Reisigl, 2017).

4.2.1.1 Step 1: Identification of the topics and texts of the discourses

The topics that make up this discourse was informed by the process of the literature review and through the process of collating the documentary archive. As the literature review was conducted, and the documentary archive was collected, I remained actively engaged with reading the texts and identifying themes that emerged and seemed apparent throughout the different texts. As I collected documents and articles, I highlighted discourse fragments that were relevant to my research and began to organize them into topics.

As noted, topics of potential interest were identified prior to reading through the documentary archive. This step occurred during the process of formulating the research question and the searching and gathering of the archive. As the overall archive was collected and reviewed, topics that were initially identified were expanded upon and refined. Throughout the first read-through of the archive, other topics were revealed. As this occurred, I set aside for more detailed analysis the texts that contained the topics and discourses I was tracking.

These topics that emerged from this process were: *vulnerability, abuse, exploitation, human rights, mental illness/health/ill health, mental disability or mental disorder.*

Vulnerability: As discussed extensively in Chapter 2, vulnerability is of specific concern in examining issues of exploitation. Throughout the archive are references to the vulnerability of people with mental illness, problems of mental health, mental disorders and mental disability.

Abuse: Abuse was selected as a theme as it encompasses activities that are of concern to exploitation. As such discourse fragments related to abuse in any form was identified, and ones that were assessed to be of most relevance to exploitation were isolated.

Exploitation: Any direct or indirect reference to exploitation was included as a topic. While numerically these are few, they were centrally relevant to the question at hand. As such in the few instances where direct mention is made, these documents were included. The lack of in-depth exploration of the term exploitation was taken to be meaningful in the analysis.

Human Rights: The theme of human rights is prevalent throughout the archive, and as the archive was collated and analysis began, it became increasingly clear that it was of great importance, both within documents and as a theme that expanded clearly throughout the three levels of documents. The important of this theme was also evident in the body of literature.

Mental illness/health/ill health: This theme encompasses discourse fragments that speak to the nature of mental illness and mental health or ill health. This includes discourse fragments that relate to how people with mental illness are represented in the archive: What is the role of people with these identities? What is their relationship with health services and society?

Mental disability/disorder: This theme encompassed reference to mental disability and disorder, which is not always used synonymously with "mental illness" or similar phrases. This is another theme that emerged as relevant primarily through the literature review, but also through the process of analysis. It became quite clear through analysis that in many cases mental disability/disorder was used synonymously with mental illness, and in other cases, it was used as a distinct category separate from mental illness. The dichotomy introduces ambiguity in the archive that has implications for the application of policy. (This is discussed in further detail in Chapter 6).

Utilizing these topics as guidelines, 10 "exemplars" from the documentary archive were selected. Specifically, documents that contained the direct references to the topics, and contained overlapping references to these topics were deemed especially relevant. Specifically, I was looking for documents that contained instances of these topics co-existing and interacting with one another. This allowed me to examine the interdiscursive relationships between the topics, and to examine how they are similar or different between texts (Reisigl, 2017).

Additionally, documents were actively sought out that represented particular perspectives at the different levels (macro/meso/micro). Thus, I wanted to search especially for documentation that represented "official" (e.g. governmental) perspectives. I then sought documents that communicated messages relevant to human rights, mental illness, and abuse/exploitation to different audiences. Specifically, at this level, I was interested in documents that deliver messages to a) professionals and b) the general public and especially c) to people who are users of mental health services.

Using these criteria, 10 exemplary documents were selected. These documents are named in Table 4.5.

Table 4.5 Representative Texts

Macro	**Document**	**Intended Audiences**
Legal	Mental Health Act (Scotland)	Policy planners
Meso		
Standards and Guidelines	Physicians: Adult Safeguarding Toolkit	Physicians and other allied health professionals in the 4 countries, including devolved countries.
	Nurses: Proficiency Standards	Registered nurses and general public
	Nurses: Code	Registered nurses and general public
	Social Work: Code of Ethics	Social workers and general public
	Police: Policing Scotland Strategy	Police, general public, policy planners, other professional bodies
Micro		
	NHS Treatment: Your Rights	Service users
	NHS The Mental Health Act: Easy Read	Service users
	Your Rights: Pamphlet	Service users
	Mental Health Advocacy & Human Rights: Your Guide (BIHR)	Service users

4.2.1.2 Steps 2/3 Investigating Discursive Strategies and Types and Tokens of Texts

Following the selection of the documents, each of the representative texts were analysed individually to understand discursive strategies utilized, and the topics present. Discursive strategies were assessed by asking such questions as (adapted from Wodak, 2001): “How are persons, objects, phenomena, events, processes and actions named and referred to linguistically?; What characteristics or qualities are attributed to social actors and phenomena?; From what perspectives are these expressed?; Are these expressed overtly? Tacitly? Do they intensify or mitigate?” (p. 10)

This occurred alongside more detailed examination of the topics that were present. Topics, and their sub-topics, are the building blocks of the discourses. Topics can be examined by describing the types and tokens that are embedded with in a text. Types and tokens are related but ontologically distinct concepts (Wetzel, 2018): Types can be understood as the *patterns* that are produced by the *tokens*, which are the actual “semiotic units” (Reisigl, 2017). That is, tokens are the statements, sentences, phrases, and so on, that are produced, distributed and received by people via the text in question.

In the analysis below, the focus will be on describing the topics that exist within each text, in order to trace which topics overlap and form larger pattern. In this process, I also consciously focused on the presence of roles and identities that are prescribed by the texts.

4.3 Internal Analysis of Representative Documents

In this section I describe each text, and describe internal themes (Reisgl, 2017), discursive strategies, intended audiences and identities formulated by each text. For each of the selected texts, I also offer a brief justification for inclusion of the document.

To reiterate, the following documents were not analysed in detail for each discourse that may or may not be present in them. Per the overall strategy of

this study, the documents were analysed specifically for the presence of specific, predetermined discourses, and other related discourses that may arise. Thus, each text was examined to describe the presence of discourses related to mental health problems/health – especially related to those who use services, the rights of those people who use mental health services, and abuse/exploitation. The documents were analysed with an intent to determine how people who use mental health services are spoken of, and how discourses are used to define service users internally.

Following this, I examine the intertextual and interdiscursive relationships formed by the archival documents studied.

4.3.1 Mental Health (Care and Treatment) (Scotland) Act 2003; The Mental Health (Scotland) Act (2015)

The Mental Health (Care and Treatment) (Scotland) Act (2003) is central to the provision of mental health service in Scotland. It outlines the legal parameters by which service providers in Scotland should address situations and issues as they arise with regards to persons engaged with the mental health service system (WHO, 2017). It identifies professionals who are empowered by the act, as well as circumstances under which those professionals are empowered to intervene with those persons. The mental health act represents the legal framework around the care and management of persons with mental health problems.

The Act was amended with an additional Act in 2015. The 2015 Act was introduced to:

> *… make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally disordered persons; and for connected persons. (p. 1).*

The Acts are produced by and for legislators. They are not intended to be received by individuals as much as it is written to be read and interpreted by persons who are experts in legislation. The language used is necessarily

precise. The intended audience of the Act is primarily legislators, and other individuals who are to be guided by a legal framework. The audience is defined in various places in the Act as “relevant persons” – who presumably should have some degree of familiarity with the contents of the law.

It is notable that in the standards of practice of the named relevant professions, a familiarity with law is a required component of practice. Thus, professional bodies such as physicians, nurses, and social workers define themselves as audiences of this law. But the technicality of the jargon excludes individuals who are untrained from being direct audiences to this law, despite often being governed by it.

People to whom the mental health act is meant to apply are often referred throughout as “the patient”. Even in portions of the act meant to address criminal acts, the language remains. This language frames people who come under the act as persons who are patients of the medical system. Another way to frame this is that the medical system has jurisdiction over those people, reinforcing the medicalization of mental health.

Specific arguments are not used in the Acts. The Acts are presented as prescriptive. There is little effort to offer justification in the Acts themselves. There are implicit appeals to authority, to science, and to the judgment of experts. For example, individuals who have received the appropriate training – generally understood to be physicians - are empowered to adjudicate risk of harm.

In terms of the language used, the mental health act is a legal document, and thus deploys technical language meant to be read and interpreted by legal experts, as opposed for general audiences.

As noted above, the 2003 Act was amended in 2015 to make provisions for “mental health disposals in criminal cases” and “… duty to inquire when evidence is found that a person under the act has experienced ill treatment or

neglect, and if that person's property may have suffered loss or damage as a result of that person's mental disorder" (p. 30).

Otherwise, the Mental Health Act is focused on the protection of society from persons who are deemed dangerous, and to protect individuals from themselves. References to "victims" are reserved for individuals who are victims of people with mental health problems who have committed a crime. For example, in Chapter 3 Section 2 (A) in reference to conditional discharge as a result of a tribunal hearing, the "Scottish Ministers must have regard to any victim's representations". There are no references to abuse, vulnerability or exploitation in the Act. References to harm and risk are used to justify detention of individuals with mental health problems – who then become "patients".

The mental health act is revisited in greater detail below due to its relevance to one of the high-level discourses that is identified.

4.3.2 Adult Safeguarding Toolkit [British Medical Association] (2020)

Regarding this document, it is important to note that health service in Scotland is devolved (Stavert, 2016), and this document was written primarily for physicians in England and Wales. However, in the introduction, it explicitly states that it is intended to provide guidance to all care workers in the 4 countries of the United Kingdom (BMA, 2018). It was chosen for analysis for this study as it contains direct reference to exploitation and the role of health service providers, as well as the fact that it explicitly states that it outlines "best practice" which is "universal" (p.1) for all UK health services professionals. As such while references to the Care Act are not directly relevant to Scottish practitioners, all other activities are stated to be "best practice" when encountering a patient suspected to be a victim of abuse or neglect.

This document was selected as it contained references to the ways in which physicians view and treat individuals who are at risk of abuse and

exploitation – people who are vulnerable, including people with mental health conditions. This document addresses the topics of Adult Safeguarding as well as describes, for physicians, what the duties and responsibilities around safeguarding and how they are impacted by issues of capacity. It states that "This toolkit explains the key concepts and responsibilities for health professionals in relation to adults who may be at risk of abuse…" (p.2)

This toolkit is written for physicians and intended to communicate to them their duties. It states in the introduction,

> *This toolkit is about doctors' role in safeguarding adults who may be at risk of abuse or neglect. (p. 1).*

People with mental health problems are often referred to in this document within the context of their capacity or lack thereof.

Examples of individuals who "may be at risk of abuse and neglect…" include "someone with mental health needs including dementia or a personality disorder"; "someone who misuses substances or alcohol to the extent that it affects their ability to look after themselves".

The toolkit states

> *The Care Act includes victims of modern slavery, domestic abuse and sexual exploitation. These are largely criminal matters and would require police involvement. (p.9)*

This sentence includes the only direct reference to exploitation and links it directly to criminality requiring police intervention.

Physician guidelines focus on adult safeguarding, which is focused on adults who may be at risk of "abuse or neglect" [which can meet the criteria of my working definition of exploitation). This can be inclusive of individuals with a mental disability. However, it is not necessarily so.

Safeguarding, according to this document, is focused on individuals who have care and support needs; and who are experiencing or are at risk of abuse or neglect; and are unable to protect themselves because of their care and support needs.

While “someone with mental health needs” may be considered a person who may fall under the Care Act, according to the toolkit, the conditions listed above mean that any person with a mental health need must also be deemed unable to protect themselves. According to the toolkit:

> *Retaining control means that competent adults have the right to assess and manage risks to which they are exposed, and support will normally involve talking through those risks and offering support where appropriate (p.23).*

The toolkit goes on:

> *In the absence of serious crime and of significant risks to third parties, competent adults retain the right to make decisions about how they wish to direct their lives. Neglecting or violating these decision making rights, even where the intention is to protect the individual, can itself be a form of abuse (p.23).*

I highlight in particular the phrase “in the absence of serious crime”. The phrase “serious crime” is undefined. Of particular interest is the use of the word “serious”. The section concludes that

> *… basic freedoms cannot be infringed. Adults are presumed to have capacity (p. 23).*

> *The fact that an adult is regarded ‘at risk’ is not by itself evidence that capacity is lacking and care must be taken to avoid any such assumption. Where an adult has capacity in relation to a specific decision, such as a health intervention, consent is required and his or her decision must be*

> *respected unless treatment is being provided under mental health legislation. (p.24)*

Finally

> *Where a health professional believes an adult with capacity is at risk of harm, but they refuse assistance, health professionals should ordinarily respect this decision but keep an accurate and contemporaneous record of the support offered and the reasons for refusal. Such decisions should also be kept under review and ongoing support should be offered (p.24).*

Adults are presumed to have capacity, and this is outlined in The Mental Capacity Act (2005). Assessments of mental capacity is decision specific to physicians (Toolkit, p. 31). According to the toolkit, the Mental Capacity Act clearly states that non-consensual treatment that is the least restrictive option should be used in every instance. Except:

> *There will be occasions however, where adults lacking capacity need to be cared for in a manner that amounts to a 'deprivation of liberty'. (p. 36).*

> *Deprivation of liberty must be authorized by a court, when necessary to give life sustaining treatment… , or in from a supervisory body under the Deprivation of Liberty Scheme. (p. 37).*

As the mental health act does with mental health problems, this document defines abuse and neglect of vulnerable adults as a professional concern, and allocates duties and responsibilities to physicians.

> *Doctors and other health professionals have considerable experience promoting the interests of their adult patients. (p. 5)*

Person centred care is addressed thusly:

Safeguarding should address the specific needs of individuals. Everyone is different and every adult receiving services will have different needs, interests and perspectives. Competent adults have a right to make decisions that affect their lives, even where this may result in risk. They may, however, benefit from additional consensual support. A person-centred approach, rooted in good communication and respectful of each person's dignity and independence, is likely to have optimal outcomes. (p.5)

4.3.3 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (Nursing and Midwifery Council, 2015)

This document was chosen as it outlines practice standards for the nursing professions. There are numerous references to both obligations to patients who are vulnerable, and to specific cases of witnessed or suspected abuse.

The point of view represented in this document is that of health services professionals – specifically nurses and midwives – as a collective. The respect in which the view of patients is represented, it is in the context of obligations or duty that nurses and midwives hold towards them. The roles of nurses and patients are represented in this document.

Nurses are required by their Standards of Practice to:

… act immediately to put right the situation if someone has suffered actual harm for any reason and to *act without delay if you believe that there is a risk to patient safety… (Standard 14.1, p.16)*

Both of these are implied to be directly related to nursing practice however.

Nurses must "raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection".

> *To achieve this, you must: Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse; Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information; Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people. (p. 16).*

Nurses are also held to the standard that they must uphold their position as a nurse by ensuring that any materials produced by nurses do "not… exploit vulnerabilities…" (Standard 21.4, p. 23), again reinforcing the link between exploitation and vulnerability.

Nurses are presented as figures of authority with "duties" (e.g. pp.9, 14, 15) to provide care, to act in particular ways that are both protective and facilitative of good health, safety and wellbeing. As noted above, nurses are held to high standards of responsibility. The language used creates the understanding that nurses have the power and authority to accomplish these tasks.

4.3.4 Future Nurse: Standards of proficiency for registered nurses (Nursing and Midwifery Council, 2018)

As with above, proficiency standards were chosen as they represent the competencies all nurses must have to meet the criteria for the profession. As such, they communicate a standard role and set of expectations for the profession. Similarly, the standards explicitly identify the expected role of nurses in relation to vulnerable people and in relation to people vulnerable to abuse.

As with the previous document, the perspective represented in this document is that of mental health service providers – specifically nurses – as a collective. Patients are represented as individuals to whom nurses have obligations and duties.

Nurses are characterized as individuals who have special privileges, but in exchange must hold themselves to a high standard of practice in delivering care using those privileges. Nurses as such are characterized as persons who are ideally diligent, knowledgeable, and responsive. They are characterized as having many roles: caregiver, educator, advocate. They are characterized as persons who should be proficient to a degree in a large range of areas, including in areas such as law and ethics. Patients are characterized as persons who benefit from this proficiency.

At point of registration, nurses are expected to be able to

> *…recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable. Standard 3.9, p. 14)*

Nurses must also be able to

> *…demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care … (Standard 4.1, p. 17)*

Nurses must be able to

> *… comply with local and national frameworks, legislation and regulations for assessing managing and reporting risks, ensuring the appropriate action is taken (Standard 6.3, p. 22)*

4.3.5 Social Work Code of Ethics (British Association of Social Workers, 2012)

The code of ethics for Social Work was chosen as it communicates expected role of social workers, especially in relation to members of society who are vulnerable.

In a very similar manner to nurses, social workers are characterized as individuals who have special privileges, but in exchange must hold themselves to a high standard of practice in delivering care using those privileges. Social workers as such are characterized as persons who are ideally diligent, knowledgeable, and responsive. They are characterized as having many roles in providing care: e.g. facilitator, educator, advocate. They are characterized as persons who should be proficient to a degree in a large range of areas, including in areas such as law and ethics. Patients/service users are characterized as persons who benefit from this proficiency.

In the Background section of the code of ethics website, it states that

> *Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to work with vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession's national and international codes of ethics. (p.4)*

Social workers have in their code of ethics the obligation to

> *"[Challenge] the abuse of human rights" (p.11)*

This aspect of the code states that

> *Social workers should be prepared to challenge oppressive, ineffective and unjust policies, procedures and practice. They should challenge the abuse of power and the exclusion of people from decisions that affect them. Social workers should strive to protect human rights and ensure their skills are not used for inhumane purposes. They should challenge and seek to address any actions of colleagues who demonstrate oppressive practice or prejudice. (p.11)*

As with the nursing code, this is aimed largely at practice environments, nested as it is under “Ethical Practice Principles”.

This particular document conveys a high level commitment to human rights and social justice. As such, this document frames individuals as inherently rights bearing and outlines responsibilities of social workers towards maintaining the rights and dignity of service users.

4.3.6 Police Scotland Strategy: Policing 2026: Our 10 year strategy for policing Scotland (Police Scotland, 2017)

It was clear from the analysis to this point that policing and criminality are consistently mentioned in the discourses surrounding mental health problems, abuse and exploitation. The Mental Health Act mentions police as a relevant profession. As such, it was necessary to assess a representative document from policing. This document was selected as it contains specific reference to the relationship between policing and mental health/illness. It was also selected as it is directly referenced in the Mental Health Strategy 2017-2027, in which the authors of the Strategy note that Police Scotland “will work with partners to intervene early to address high impact issues such as mental health problems” (p.19). The Mental Health Strategy references the need for strategic partnership with Police Scotland and the Justice System throughout.

In this document, the point of view represented is that of the police, who in turn are represented as holding responsibility for maintaining order and safety for the public. Persons with mental health problems are represented as a potential source of disruption to that safety, but are also represented as persons who require special attention. There is some choice of language that seems to indicate a concern for the safety of persons with mental health problems, such as reference to their vulnerability.

Under the title “Demands We Face Every Day”, it states:

> *Vulnerability and People in Crisis: 1 in 4 people suffer from a mental health issue in any given year. As a result a*

> *proportion of these people come to the attention of the Police for various reasons. The most common marker on the police vulnerable persons database is mental health. As a result of attending various types of incidents last year officers recorded around 57000 mental health entries on the database. (p. 22)*

It is notable that this does not address vulnerability beyond the subheading. Nor is there specific reference in the strategy to how the Police force should responds to this increased need, or to the people with mental health issues as particularly vulnerable to victimization.

This document states that “mental health issues will become more common”. This is named as one of “the Demands We May Face in the Future”. Under the subheading “Impact on Policing” that

> *Continued inequality will place a high demand on policing and other public services, along with demand associated with mental health and vulnerability. More preventative approaches will be required to intervene at an early stage to reduce the potential for harm and manage demand on services. (p. 24)*

This nature of the subheadings and the statement emphasizes that mental health and vulnerability is an issue to be dealt with via policing. It doesn’t frame it as injustice that policing may help mitigate, but a factor that will drive up demand for (presumably traditional, enforcement style) policing.

4.3.7 NHS Treatment: Your Rights Factsheet (from “Rethink Mental Illness” Website) (Rethink Mental Illness, 2015; updated 2021)

This document and the one following are both selected due to them being targeted at casual readers. In this way, these set the tone and define the ways readers are expected to receive the messages about rights and laws.

They are from the Rethink Mental Illness Charity, a mental health organization supporting persons with mental illness.

This document is directed at persons who use services provided by the NHS, especially those who use mental health services. While it provides information to service users about their rights within the system, it reinforces the traditional relationships that service users hold with service providers. For example, it reinforces the roles physicians have as expert (while stating that the patient has the right to refuse treatment from the physician). It states that health service providers, especially physicians, need to take the patients' needs and preferences into consideration.

In the section on Human Rights, this document states:

> *NHS services must respect your human rights. For example, they have to respect your private and family life. Your human rights may be affected in the following situations. (p 3)*

This is notable as this defines these actions which are fairly typical as rights violations, which is quite unique in the archive.

> *Being placed in a residential unit a long distance from your family; Keeping you secluded, alone in a room and supervising you, without good reasons that consider your rights; Refusing to allow family visits or contact when you are in hospital; Excessive force used to restrain you. (p. 3)*

> *But some of your human rights, including your right to a private and family life, are not 'absolute'. This means that your rights can be restricted if the restriction is lawful. This means that there must be a law allowing the restriction. Such as the Mental Health Act or Mental Capacity Act and for a legitimate reason. For example, the need to protect you or other people; necessary and proportionate. This means that*

the NHS must be able to show that they have thought about your rights. And that the restriction is

"…as minimal as possible to achieve a legitimate aim." (pp. 3-4)

This also is fairly unique in the archive, in that it delineates limits to rights that are generally defined by the status of the individual as having a mental health problems.

4.3.8 NHS Mental Health Act: Easy Read (from NHS Website) (National Health Service, 2020, reviewed 2022)

As above, this document was selected due to the source being from the NHS, and it being directed at people who are seeking easy to access information on the mental health act. It thus serves as a gateway of information from an authoritative source to members of the general public.

This document represents the government, formal position. It outlines the laws that govern people with mental health problems. The voice of people with mental health problems is not represented in and of itself. It reinforces the existing structures and relationships in the medical system. As it would perhaps be expected, the messaging does not deviate from that of the mental health act proper. It is simply presented in a simplified manner that is more accessible than the act itself. Thus the construction of identities communicated is not changed in any significant manner. This is relevant in that this document is intended for a broader audience. Thus, it can be concluded that the transmission of messaging from the Act is carried through in this manner, via the NHS, to individuals within society.

This document is particularly notable due to its largely formal tone, and ironically quite difficult to follow construction. This is despite the fact that it is intended to make the mental health act accessible.

4.3.9 Your Rights (from Scottish Association for Mental Health website) (Scottish Association for Mental Health, Retrieved 2020)

This document is intended for individuals with a mental health condition. It is a simple one page document that lists rights. Among the rights listed is that

> *"People with mental health problems have the right to not suffer exploitation, violence and abuse". (para. 1)*

This document represents the point of view of persons who use mental health services, and constructs this role from an empowered perspective.

The intended audience of this document is individuals with a mental health condition. The producers of the document are advocates of persons with mental health conditions. It appears to be intended to be an easy-to-read and understand document outlining the rights of persons.

Here, what is not said is relevant: There are no references to limitations on these rights. There is no reference to the mental health act. It is a notable contrast with the NHS document which clearly and early on delineates the limitations to rights based on the mental health act and capacity.

It is written in a clear and straightforward manner. Visually, it is not cluttered. This makes it accessible to readers.

The audience is represented to be rights-holders, individuals who have the clear and non-conditional right to participate in community and cultural life, and to live free of abuse and exploitation. They are represented to be people who have the right to the same access to community and the same interactions with others that the general public has. This includes the right to access supports, which would then mitigate the effects of their illness or their vulnerability and marginalization.

At the bottom, emphasized by bold and italicized text is the phrase:

> *… it is illegal for someone to discriminate against or harass you because you have a mental health problem when you are accessing health services and social services. (para. 4)*

4.3.10 Mental Health Advocacy & Human Rights: Your Guide (From the British Institute of Human Rights, 2013)

This document was selected as a document that is explicitly intended to communicate directly to individual service users what their rights are with relation to the system. It can thus be inferred that it contains specific language that is intended to communicate identities. However, as with the previous document, it was produced by an institution not within the governmental mental health service providers such as the NHS. And thus it can be assumed it would provide a different lens through which it portrays mental health service users, their roles, and their relationship with services.

The intended audience of this document is specifically advocates of people who use mental health services, and it constructs this role from an empowered perspective. The producers of the document are advocates of persons with mental health conditions. It appears to be intended to be an easy-to-read and understand document outlining the rights of persons. This document contains language that emphasizes the rights of individuals. It does not assume background knowledge but is comprehensive.

In terms of patterns traceable in this document, one can note discourses that emphasize the rights of individuals with mental health problems. Risks posed by persons with mental health problems are not emphasized in any fashion. While the audience is explicitly laypersons (people with no background understanding of human rights) it does not ‘water down’ the knowledge or information that it contains.

The document outlines the “key human rights relevant to mental health”. It identifies the “right to dignity” the right to fair treatment/non-discrimination. It references legal cases where those rights were tested in courts. It provides case studies relevant to mental health/illness. In these case studies, it

references individuals with severe and enduring types of mental illness – e.g. schizophrenia, and the protection of the rights of those persons as well.

Despite the emphasis on rights the document in places makes reference to limits on rights in specific language… for example, it states that detention under the mental health act is not a violation of rights

"…unless it is unlawful (p.11).

This assumes that the mental health act is aligned with human rights.

4.4 Topics and Tokens of the Exploitation Discourses

Table 4.6 (below) contains a summary of the relevant discourse fragments identified in the above documents. The "tokens" refer to the actual text and language utilized. The topics are the discursive themes that the tokens are related to. In each row I have identified the initial identified topics as well as any other topics that emerged through the process of analysis. The so-called "types" are the patterns and meanings that emerge from the use of language. These meanings can include both intended meanings as well as meanings that may not be intentional – that may be subconscious or subliminal.

Table 4.6 Types, Tokens and Topics of the Representative Texts

Document	Types (Patterns/meanings)	Tokens (Actual language utilized)	Topics
Mental Health Acts: Mental Health (Care and Treatment) (Scotland) Act 2003; The Mental Health (Scotland) Act (2015)	Persons with mental illness are subject to legal scrutiny Persons with mental illness have the right to live without abuse (Ill treatment or neglect) Relevant professionals should intervene and provide support in cases of abuse Autonomy ought to be respected (value judgment)	"Patients" (e.g. p.1) "to the rights of victims of crime committed by mentally disordered persons" (p.1) "the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation (p. 2)."	Vulnerability, abuse, mental illness/health/ill health, mental disability or mental disorder Other topics identified: Harm

	There is a danger present with the presence of mental illness.		
Adult Safeguarding Toolkit	Mental illness may cause disability People with capacity have the right to make mistakes. Physicians have duty to protect	"There will be occasions however, where adults lacking capacity need to be cared for in a manner that amounts to a 'deprivation of liberty'." (p. 36). "Where a health professional believes an adult with capacity is at risk of harm, but they refuse assistance, health professionals should ordinarily respect this decision but keep an accurate and	Vulnerability, abuse, human rights, mental illness/health/ill health, mental disability or mental disorder

	Rights must be respected	contemporaneous record of the support offered and the reasons for refusal. Such decisions should also be kept under review and ongoing support should be offered". (p. 24) "The fact that an adult is regarded 'at risk' is not by itself evidence that capacity is lacking and care must be taken to avoid any such assumption. Where an adult has capacity in relation to a specific decision, such as a health intervention, consent is required and his or her decision must be respected unless treatment is being provided under mental health legislation". (p. 24) "… basic freedoms cannot be infringed" (p. 23) "In the absence of serious crime and of significant risks to third parties, competent adults retain the right to make decisions about how they wish to direct their lives. Neglecting or	Other topics Identified: Best practice Role of physicians Abuse Neglect Exploitation Mental illness Harm Criminality Autonomy

		violating these decision making rights, even where the intention is to protect the individual, can itself be a form of abuse" (p. 23).	
The Code: Professional Standards of Practice for Nurses, Midwives & Nursing Associates	Central role of nurses to protect the vulnerable Duty to protect	"act immediately to put right the situation if someone has suffered actual harm for any reason" (p. 14)	Vulnerability, abuse, mental illness/health/ill health, mental disability or mental disorder

		"act without delay if you believe that there is a risk to patient safety…". (p. 16) Nurses must "raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection". (p. 18) "To achieve this, you must: Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse. Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people." (p. 18)	Best Practice

Future Nurse: Standards of proficiency for registered nurses	Duty to abide by regulations Duty toward professional behaviour Duty to protect	"recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable". (p. 14). "demonstrate and apply an understanding of what is needed for people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met…" (p. 16) "comply with local and national frameworks, legislation and regulations for assessing managing	Vulnerability, abuse, human rights, mental illness/health/ill health, mental disability or mental disorder Risk Harm Laws and Regulations Autonomy

		and reporting risks, ensuring the appropriate action is taken" (p. 22)	Dignity Safety
Social Work Code of Ethics	Social workers as active agents Service	"Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to work with vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession's national and international codes of ethics." (p. 4) "[Challenge] the abuse of human rights". (p. 8) "Social workers should be prepared to challenge oppressive, ineffective and unjust policies, procedures and practice. They should challenge the abuse of power and the exclusion of people from decisions that affect	Vulnerability, abuse, human rights, mental illness/health/ill health, mental disability or mental disorder Autonomy Safety Social justice

		them. Social workers should strive to protect human rights and ensure their skills are not used for inhumane purposes. They should challenge and seek to address any actions of colleagues who demonstrate oppressive practice or prejudice." (p.8)	
Policing Scotland: Strategy	People with mental illness as potentially criminal Duty to protect vulnerable persons	"1 in 4 people suffer from a mental health issue in any given year. As a result a proportion of these people come to the attention of the Police for various reasons." (p. 22) "The most common marker on the police vulnerable persons database is mental health" (p. 22) "mental health issues will become more common". (p. 24) "the Demands We May Face in the Future". (p. 24)	Vulnerability, Human rights, Mental illness/health/ill health, Mental disability or mental disorder Harm Public Safety Vulnerability

		"Continued inequality will place a high demand on policing and other public services, along with demand associated with mental health and vulnerability." (p. 24) More preventative approaches will be required to intervene at an early stage to reduce the potential for harm and manage demand on services." (p. 24)	
NHS Treatment: Your Rights	Persons with mental illness as deserving of rights	"NHS services must respect your human rights. For example, they have to respect your private and family life. (p. 3) "Your human rights may be affected in the following situations…" (p. 3)	Vulnerability, human rights, mental illness/health/ill health, mental disability or mental disorder Human Rights Respect

NHS The Mental Health Act: Easy Read	Informative		Vulnerability, human rights, mental illness/health/ill health, mental disability or mental disorder
Your Rights (SAMH)	People with mental illness as deserving of rights	“People with mental health problems have the right to not suffer exploitation, violence and abuse”. (para. 1).	Vulnerability, human rights, mental illness/health/ill health, mental disability or mental disorder Explicit mention of exploitation
	Human rights as tripartite	“Respecting your human rights: this means not doing something which	Vulnerability, human rights, mental illness/health/ill health,

Mental Health Advocacy & Human Rights: Your Guide (BIHR)		restricts your human rights (it is sometimes called a negative obligation). For example the right to be free from inhuman and degrading treatment (Article 3) means a public authority should not treat you in such a way. (p. 7)" "Protecting your human rights: this means public authorities must take action to prevent human rights abuses (this is called a positive obligation). This can sometimes include taking action to prevent non-public officials from harming you." (p. 7). "Fulfil your human rights: this means public authorities should take steps that strengthen access to and realisation of human rights. It is sometime called a procedural or process obligation because it includes having systems in place to prevent or investigate human rights abuses. For example, the death of a person detained in a mental health	mental disability or mental disorder

		hospital should be investigated (usually an inquest).” (p. 7)	

4.5 Emerging Themes

The analysis revealed a dichotomy of principles and expectations with regards to abuse and exploitation, and how service providers should and do address it. Firstly, there are some statements that service providers have a moral and professional obligation to protect people with mental illness (and indeed all vulnerable persons) from abuse and exploitation (see table 4.6, where explicit and implicit reference to exploitation is noted). While these statements are few in number, they are unambiguously worded. On the other hand, the specific interventions that are described are legal ones, which only come into effect once conditions are met. Those conditions are a) if a crime has been committed, especially if a third party is at risk and b) if the person, due to their illness, lacks capacity to consent to specific situations that might result in a degree of harm to their self. These conditions have a high bar. Thus, when it comes to the types of exploitation that are of concern to this research – specifically noncriminal exploitation - there are no prescribed actions or responsibilities in the texts. The exhortations that professionals must intervene when harm is being enacted on vulnerable persons only come attached to vague notions of “providing support” “as appropriate”. Thus when it comes to the responsibilities and duties of professionals to intervene when it comes to noncriminal exploitation, there are no actions that are actually defined within the textual archives. [And further, there are none that are possible without restructuring the way mental health/illness are addressed – this is discussed in detail in Chapter 6].

4.6 Exploitation in the Discourse: Interpretation

The first, and most relevant finding to this study, was that a concern about exploitation of people with mental health problems is nearly absent in all forms within the archive.

The topic of exploitation – and related topics - are far more prominent in their absence in the archive than in their presence. As discussed previously, the absence of voices or discourses can be as revealing as the presence of discourses and is of academic interest. The prominent absence of any

meaningful discussion of exploitation prompted reflection on the meanings behind the absence.

First, there are numerous references throughout the archive regarding the vulnerability of people with mental health problems. “Vulnerability” in fact, seems to be a common lens through which to view people with mental health problems in almost every document. As discussed in Chapter 2, the presence of vulnerability is a key feature of exploitation.

However the presence of vulnerability does not necessitate that these particular texts, and health service providers, need to be particularly concerned with exploitation. However, as seen in Chapter 2, exploitation is generally defined as a sub-form of abuse (Wertheimer, 1992). Throughout the archive, health service providers are identified as persons who are a) explicitly concerned with the abuses suffered by those in their care and b) specifically trained and given authority to intervene on behalf of those vulnerable persons who are experiencing abuse. In fact, throughout the archive, specific references to abuse are often left to generalities. There is no mention of exploitation by name in any meaningful sense.

However, while specific concern for abuse is identified, there is conflicting identification of the need to respect the autonomy of people in care (such as in the Adult Safeguarding Toolkit), which is inclusive of allowing them to consensually engage in activities which may be harmful to them. There is therefore an assumption within professional guidelines that people who are vulnerable or at risk do not *necessarily* lack capacity.

This creates a dilemma for mental health service providers wherein patients may be ‘deemed’ or assumed to have capacity to make decisions, but may be engaging in behaviours that are (for example in the case of exploitation) potentially harmful to the patients’ wellbeing. This provides a moral dilemma in the case where this may contrast with the obligation to protect patients from known harms – especially as they relate to vulnerability.

In the process of analysis, this understanding created the first sense that there is an inherent tension within the discourses, and that the issue of exploitation of people with mental health problems is affected by this tension. The tension was illuminated by further analysis, which led to the discovery of two other, broader discourses present in the archive, and which supersede the discourses of exploitation and abuse. These two discourses are discussed here.

4.7 Prominent Discourses

Further analysis of these documents revealed the presence of a number of prominent discursive themes. These two prominent themes supersede discourses of abuse and exploitation. These macro-discourses define the position of individuals with mental health problems in broader society. These discourses I describe below, and name the Rights-Autonomy Discourse and Harms-Paternalist Discourse for simplicity. These names are selected as they capture the identities created for people with mental health problems, as either rights-bearing, autonomous and vulnerable to stigma; or as people who are potentially harmful and for whom risk is an inherent feature.

These discourses are prevalent throughout the archive, and are embedded within the various health service documents analysed. Due to their ubiquity throughout the entirety of the archive, I identified these two discourses as essential to understanding the relationships that mental health services have with society and with people who use services.

This section addresses how topics are linked between texts and thus create these two parallel intertextual discourses:

1. People with mental health problems are rights bearing, autonomous, worthy of respect. As far as abuse/exploitation go, these individuals are vulnerable and should be actively supported in their independence and have a right to exist free from abuse. The symptoms of their illness are of secondary concern to their vulnerability within society.

2. People with mental health problems are potentially dangerous, burdensome, non-contributing to society, non-productive. The symptoms of their illness are of greater concern and should be managed so as to not present a risk to self or others. As far as abuse/exploitation go, these individuals are often not competent to manage their own affairs, they may have their legal right to make decisions suspended based on their illness presentation. This discourse is often presented as a justification for limiting rights.

These two types of discourses exist side by side within the archive, and in many cases, within the same document – they create a zone in which professionals can struggle to understand what their role is, and how they should address individuals, especially those who are experiencing abuse and exploitation.

4.7.1 The Rights-Autonomy Discourse

This macro-discourse is in many ways more difficult to elucidate than the Harm-Paternalist discourse. As will be discussed, the presence of this discourse is emerging, and seems more aligned with activist groups, mental health advocacy groups, and the discourses from rights-based care spearheaded by organizations such as the World Health Organization. There is acknowledgment and uptake of this discourse within the service documents and policies within the archive, but this discourse does not *originate* in these documents. This is an important point that will be highlighted in further chapters.

4.7.1.1 Topics in the Rights-Autonomy Discourse

The different aspects of each discourse are represented in the various documents. Table 4.7 below contains the ways in which the topics associated with the Rights-Autonomy discourse are present within the 10 representative documents.

To summarize the topics within this discourse: This discourse situates people with mental health problems as rights bearing, autonomous, and worthy of

respect. As far as abuse/exploitation go, these individuals are *vulnerable* and should be actively *supported* in their independence and have a right to exist free from abuse. The *symptoms of their illness* are of secondary concern to their vulnerability within society. Note here that I intentionally identify this topic as “vulnerability” rather than a different terms such as “marginalized” or otherwise. This is due to the phrasing of language within the documents.

Thus, the topics identified (and further described below) are *rights bearing, autonomy and vulnerability.* Table 4.7, below, will demonstrate the relevant textual fragments (tokens) that support these topics.

People with mental health problems as rights-bearing: Major features of the Rights-Autonomy Discourse are autonomy or self-responsibility. The role of a person with mental health problems within this discourse is that they are Rights-bearing individuals, as described in the various human rights codes. That is, they are people who are owed the same access to human rights as any other person, despite their mental health problems. They are able to contribute to society if supported. People should be allowed to live as everyone else unless symptoms necessitate extra support.

Autonomy: References to employment and education are usually described in terms of the right to equal access.

Vulnerability: Vulnerability is often described as occurring due to stigma and discrimination. Supportive actions are described in terms of community supports, person-centered, and rights-based. **Exploitation** is closely related to this discourse and in some instances seems to be intrinsically linked to it, in that people are understood to be vulnerable to abuse and exploitation due to stigma and societal discriminations. However, given the central importance of exploitation to this thesis, it will be highlighted where it exists on its own.

The vulnerability of people with mental health problems is present in both discourses, but how vulnerability should be addressed is different between them. In the Rights-Autonomy discourse, individuals who are vulnerable

should be supported by addressing stigma, by providing equal opportunity to care and employment. Stigma is the root cause of abuse suffered by people with mental health problems. The contrast (and tension) between individual level issues and community level interventions is further explored in Chapter 6.

The relationship between “vulnerability” as expressed between the two discourses will be explored in greater detail in Chapter 6.

Rights-Bearing: Consistent with the findings in the literature, the notion of people with mental health problems as explicitly worthy of holding basic human rights is prevalent in the representative texts. While these rights are sometimes noted to be limited by various factors, the texts tend to be unequivocal in statements that persons with mental health problems are intrinsically worthy of all basic human rights on the face.

Table 4.7 Examples of Topics in the Rights-Autonomy Discourse and associated text fragments

Document	Discourse Fragments/Tokens	Topics
Mental Health Acts: Mental Health (Care and Treatment) (Scotland) Act 2003; The Mental Health (Scotland) Act (2015)	"…the need to ensure that, unless it can be shown that it is justified in the circumstances, the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation (p. 2).	Autonomy Rights-bearing

Physicians: Adult Safeguarding Toolkit	"… basic freedoms cannot be infringed". Adults are presumed to have capacity (Toolkit, p. 23). "The fact that an adult is regarded 'at risk' is not by itself evidence that capacity is lacking and care must be taken to avoid any such assumption. Where an adult has capacity in relation to a specific decision, such as a health intervention, consent is required and his or her decision must be respected unless treatment is being provided under mental health legislation. (p. 24) Where a health professional believes an adult with capacity is at risk of harm, but they refuse assistance, health professionals should ordinarily respect this decision but keep an accurate and contemporaneous record of the support offered and the reasons for refusal. Such decisions should also be kept under review and ongoing support should be offered. (p. 24)	Rights-bearing Autonomy Vulnerability

Nurses: Proficiency Standards	"recognize and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable". (p. 14)	Vulnerability
	"demonstrate and apply an understanding of what is needed for people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met…" (p. 16)	Rights bearing
	"comply with local and national frameworks, legislation and regulations for assessing managing and reporting risks, ensuring the appropriate action is taken" (p. 22)	Rights bearing

Social Work: Code of Ethics	“Human rights and social justice serve as the motivation and justification for social work action” (p. 1)	Rights bearing
	“[Social workers] act ethically and have the professional rights necessary to protect and promote the rights of people who need to or who access social work services” (p. 4)	Rights bearing
	“Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to work with vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession’s national and international codes of ethics.” (p. 1)	Vulnerability
	“[Challenge] the abuse of human right”. (p.	Human Rights
	“Social workers should be prepared to challenge oppressive, ineffective and unjust policies, procedures and practice. They should challenge the abuse of power and the exclusion of people from decisions that affect them. Social workers should strive to protect human rights and ensure their skills are not used for inhumane purposes. They should challenge and seek to address	Rights bearing

	any actions of colleagues who demonstrate oppressive practice or prejudice.” (p. 11) “Social workers have a responsibility to challenge oppression on any basis, including (but not limited to) age, capacity, civil status, class, culture, disability, ethnicity, family structure, gender, gender identity, language, nationality (or lack of), political beliefs, poverty, race, relationship status, religion, sex, sexual orientation or spiritual beliefs.” [note here that mental illness or status is not mentioned explicitly] (p. 7) “Social workers should recognise that people using social work services have the right to take risks and should enable them to identify and manage potential and actual risk, while seeking to ensure that their behaviour does not harm themselves or other people” (p. 9)	Rights bearing (right to take risk) Vulnerability
Police: Policing Scotland Strategy	“The most common marker on the police vulnerable persons database is mental health” (p. 22)	Vulnerability
NHS Treatment: Your Rights	“NHS services must respect your human rights. For example, they have to respect your private and family life. (p. 3)	Rights bearing
Your Rights: Pamphlet (SAMH)	People with mental health problems have the right to not suffer exploitation, violence and abuse”. (para. 1)	Rights bearing

		Vulnerability

4.7.2 The Harm-Paternalist Discourses

The Harm-Paternalist Discourse is so named because of the identity of the person with mental health problems defined by the discourse – that of being harmful or dangerous to society; and because of the prescriptive activities that healthcare services provide for people within this discourse – that of paternalistic measures.

Perhaps not surprisingly, this discourse is easier to describe in detail. It represents a view of mental health problems that is more firmly rooted in the historical contexts and medical contexts described in Chapter 2.

The way people with mental health problems are described in the discourse – and therefore the identity that is formed for them - is thus: That they are *potentially dangerous, burdensome, non-contributing to society, non-productive.* The symptoms of their illness are of greater concern and should be managed so as to not present a risk to self or others. As far as abuse/exploitation go, these individuals are *often not competent* to manage their own affairs, they may have their legal right to make decisions suspended based on their illness presentation. This discourse is often presented as a justification for limiting rights.

This Macro-discourse in the textual exemplars focuses on the potential harms and risks to society that are posed by people with mental health problems. In these discourses, people with mental health problems are dangerous, burdensome, and are non-productive, which means they do not contribute to society as others do. They are external to “normal” society, require monitoring, supervision and, when needed, involuntary treatment.

In regard to abuse and exploitation, people with mental health problems are often judged (by service providers) to not be competent or are understood to be unable to (due to symptoms) make decisions or manage their own affairs. This makes them “natural” targets for abuse and exploitation. This can be addressed through legal frameworks via the mental health legislation

(mental health act, powers granted to physicians/GPs/allied professionals and police).

The major features of the Harms-Paternalist Discourse are: People with mental health problems are inherently a risk to society. There is a natural association between mental health services and policing. They should be monitored as such, by health professionals, who are given authority over the freedom of their movements and choices based on their (the service provider's) judgment.

As with the Rights-Autonomy Discourse, vulnerability is a feature. It is acknowledged within this discourse that people with mental health problems are vulnerable, and that vulnerability is in part a feature of stigma. However, within this discourse, how the vulnerability should be addressed is embedded in notions of paternalism. People are variably competent to make their own decisions, and thus should be allowed to engage freely in abuse or exploitative relationships. Only should they be deemed incompetent – an option that is available – are measures available to intervene. These measures, notably, may involve further restrictions on the rights of the person with mental health problems, such as the use of involuntary admission or involuntary treatment, or community orders (citation). This is reflective of the paternalistic nature of the prescribed actions described by the discourse. Paternalism is described as

> *the policy or practice on the part of people in authority of restricting the freedom and responsibilities of those subordinate to or otherwise dependent on them in their supposed interest (OED online, 2022).*

This definition is particularly apt as it encompasses the power differential that is inherent in paternalism, and is a notable feature of this discourse. Throughout the archive, there are references to the obligation of health care professionals to act as protectors, of either people with mental health problems, or of others in society from people with mental health problems.

People with mental health problems therefore, are inherently requiring oversight and monitoring.

4.7.2.1 Topics in the Harm-Paternalist Discourse

As with the Rights-Autonomy discourse, these discourses are present in textual fragments as seen in Table 4.8.

To summarize the topics, people with mental health problems are positioned as people who are *potentially dangerous*, to themselves and to others. They are *non-productive* in that they do not necessarily engage with employment or education, which makes them potentially *burdensome* to others and society. They are *vulnerable*, and they are more likely to require *medical care.*

To provide further detail:

Potentially dangerous: This topic emerged as a prominent theme, due in large part to the close association between mental health/illness and the criminal justice system. The constant references to the criminal justice system and their positioning as a central provider of mental health services emphasises the potential criminality of persons with mental health problems. These reference to criminal justice are rarely qualified with reference to *actual crimes* committed by persons with mental health problems. There are numerous references to the role of policing in contacts with persons with mental health problems, as well as the role of criminal justice with regards to the mental health act. The potential for dangerous action to self or to others is the most commonly cited reason for restriction of rights (as will be further discussed below)

Non-contributing to society, non-productive: There are numerous, repetitive references to the ability of individuals to be productive and contributing members of society, as an end goal or best outcome of addressing mental health problems. As will be seen, this particular topic is in the Strategy as well.

Burdensome: The topic of individuals as burdensome arises in part from the topic of non-contributing to society/non-productive. In this, people are naturally burdens to or drains on society. They utilize social assistance programs and require extra support from social programs.

Vulnerability: This topic is one that overlaps between this discourse and the Rights-Autonomy discourse. There is little to distinguish the topics themselves between the two discourses, but the relationship vulnerability has with other topics is modified by how it is being utilized. The relationship between “vulnerability” as expressed between the two discourses will be explored in greater detail in Chapter 6.

It is notable that these discourses are most explicitly present in 4 of the 10 exemplar documents. This might signal a move away from historical discourses towards rights-based discourses on one hand. However, this is belied by the fact that the discourses are much more strongly represented. That is, as will be noted further in Chapter 5, the Rights-Autonomy discourses are associated with language that is more vague, with fewer concrete actions associated. The Harms-Paternalist discourse is associated with strong concrete actions and resource. This potentially reflects an awareness of public attitudes towards people with mental health problems, and an attempt (conscious or unconscious) to mitigate the possible harms that people with mental health problems might cause. Public perception is discussed further in Section 4.8.4, and the effects of this perception on mental health services is addressed further still in future chapters.

Table 4.8 Examples of Topics in the Harm-Paternalist Discourse and associated text fragments

Document	Discourse Fragments/Tokens	Topics
Mental Health Acts: Mental Health (Care and Treatment) (Scotland) Act 2003; The Mental Health (Scotland) Act (2015)	… mental health disposals in criminal cases" and "to make provision as to the rights of victims of crime committed by mentally disordered persons… See section 4.7.3 for more detailed analysis.	Potentially dangerous
Physicians: Adult Safeguarding Toolkit	Adults with care and support needs who may be at risk of abuse and neglect can include: – an older person who is particularly frail – someone with mental health needs including dementia or a personality disorder – a person with a significant and impairing physical or sensory disability – someone with a learning disability – a person with a severe physical illness – an unpaid carer who may be overburdened, under severe stress or isolated – a homeless person – someone who misuses substances or alcohol to the extent that it affects their ability to look after themselves	Medical care Vulnerable Nonproductive

	– someone living with a person who abuses substances or alcohol – women who may be particularly in need because of isolating cultural factors. This list is not exhaustive. The Care Act includes victims of modern slavery, domestic abuse and sexual exploitation. These are largely criminal matters and would require police involvement; they are discussed in more detail later in this toolkit. (p. 9)	
Nurses: Proficiency Standards	Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect. (p. 39)	Vulnerable
Social Work: Code of Ethics	Social workers should recognise that people using social work services have the right to take risks and should enable them to identify and manage potential and actual risk, while seeking to ensure that their behaviour does not harm themselves or other people.	Vulnerable
Police: Policing Scotland Strategy	We will maintain a key role in supporting vulnerable individuals and communities. Working with partners, we will intervene with them at an early stage to address high impact issues such as domestic abuse, substance misuse, sexual offending and mental health. (p. 29) Continued inequality will place a high demand on policing and other public services, along with demand associated with mental health and vulnerability. More preventative approaches will be required to intervene at an early stage to reduce the potential for harm and manage demand on services. (p. 24)	Potentially dangerous

	More preventative approaches will be required to intervene at an early stage to reduce the potential for harm and manage demand on services.” (p. 24)	
NHS Treatment: Your Rights	“Your human rights may be affected in the following situations…” But some of your human rights, including your right to a private and family life, are not ‘absolute’. This means that your rights can be restricted if the restriction is: • lawful. This means that there must be a law allowing the restriction. Such as the Mental Health Act or Mental Capacity Act, • for a legitimate reason. For example, the need to protect you or other people, • necessary and proportionate. This means that the NHS must be able to show that they have thought about your rights. And that the restriction is as minimal as possible to achieve a legitimate aim. (p. 3)	Potentially dangerous
Your Rights: Pamphlet (SAMH)	“People with mental health problems have the right to not suffer exploitation, violence and abuse”. (para. 1)	Vulnerable

4.7.3 The Mental Health (Scotland) Act (2003) and the Mental Health (Scotland) Act (2015)

The mental health acts of Scotland deserve special mention and analysis in relation to the Harms-Paternalist discourse. The Mental Health Act is one of the most important documents in the archive in large part due to the power it has over the lived experiences of people with mental health problems, and who encounter mental health services in Scotland. It is noted above in that it is in many ways structured around the potential criminality of people with mental health problems. In fact, much of the content of the Act is around the need to protect others from people with mental health problems. For example, the Act outlines the requirement that medical officers consider the following in transfer decisions: "… whether, as a result of the patient's mental disorder, it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment" (Part 11; Section 206, 3(b)). Here I emphasize the reference to "whether or not for medical treatment". This illustrates the power of medical officers to make judgments that are generally reserved for the judicial system.

Further to the point, in 33 mentions of the word "harm" in the 2003 act, 27 of them are in reference to the potential of harm to another person", with the rest reserved for reference to potential to harm to the patient. Only one reference is in relation to the patient's potential risk of suffering harm as a result of their illness". An entire section of the Act, Part 8, is dedicated to criminal proceedings against persons with mental disorders. There are numerous references in the Act to other acts involving criminal procedures, and this Act replaced or repealed sections or whole criminal acts (see Schedule 5 Repeals and Revocations).

Whilst there are logical reasons for crime to be addressed in a mental health act, the extent to which the Act is focused on criminality is striking, especially in relation to any other issue. Interestingly whereas, as noted, "harm" is

referenced 27 times in relation to patient's potential to commit harm upon others, the phrase "rights" in reference to patient rights occurs only 18 times.

A word cloud – which illustrates the relative frequency of words that appear in the act - generated from the Act, provides some further insights. Word clouds can be useful tools for preliminary analysis of a text, as well as for confirming initial analysis (McNaught & Lam, 2010). The repetitiveness and thus emphasis of words might create a sense of importance or emphasis to the reader. For example, when one looks for identity forming phrases that could apply to persons with mental health problems (beyond a generic reference to "person"), one finds the phrases "patient" and "offender". Other identify forming phrases are for people on the "other side" of the issue as it were": "managers, ministers, practitioner". The most commonly used identity forming phrase is "officer" (i.e. medical officer). The word cloud does not contain any words that could be reasonably included in the "Rights-Autonomy" discourse.

The use of the word cloud is not meant to provide analysis beyond what is described above. The intent of the use of the word cloud is to provide insights into the emphasis placed on certain concepts – in the form of attention to those concepts. This is intended to represent the principle of critical discourse analysis that the way language is utilized matters, and specifically the selection of words should be carefully considered as to what meaning it is meant to convey. Further, the emphasis placed on these words, as represented by the relative frequency of their useage, demonstrates a sense of the content of the document. I argue that the frequency of useage of words such as "patient, treatment, medical, tribunal" and an absence of words that are used by advocacy groups, such as "empowerment, wellbeing" demonstrates the stronger alignment with the Harms-Paternalist discourse than with the Rights-Autonomy discourses.

Figure 4.2 Word Cloud for Mental Health (Care and Treatment) (Scotland) Act 2003

(This word cloud was generated using Nvivo software)

4.7.4 Harm-Paternalist Discourses in Popular Media

These discourses that have been described are evident not only within documentation intended for mental health service (and other health service) professionals, but in other forms of documents as well, that are produced for and by laypersons.

Given the broad array of materials that may be assessed for the presence of these discourses, it's impossible to ascribe even a handful of potential motivations to how and why these discourses are deployed in popular media. A newspaper article, for example, will deploy or emphasize varying discourses depending on the content of the article and the message the journalist is conveying. Media such as television or film likewise will deploy the discourses for the effect they have: The Harms-Paternalist Discourses may be emphasized to convey a sense that an individual character is distrustful, malevolent or dangerous. Likewise, Rights-Autonomy Discourses

may be deployed to induce a sense of sympathy for a character. There is evidence to suggest that media representations of mental health problems are overwhelmingly negative, and have a cumulative effect on the public consciousness in regards to how they view people with mental health problems (Pavelko & Myrick, 2016; also see Pirkis et al., 2006).

In film for example, the notion that individuals who are mentally ill are dangerous, has become a narrative shorthand. It is by now a well-recognized and long-standing trope within the media to represent people with mental health problems as criminal, erratic, dangerously unstable (Nairn, 2007; Frese et al., 1997). Films and television often portray the “bad guy” as an individual whose behaviour is consistent with mental health problems (Evans, 1996). In fact, this is often a ‘shortcut’ to the audience understanding a character to be evil. Rather than expositions regarding motivation it is simple to deploy the “madness” of a character as way of easily conveying the nuances contained within what I describe as the “harm” discourse: Namely, that someone who is “insane” is automatically likely to disregard the law, prioritize their own wellbeing, lack empathy, and fail to contribute in a positive way to society.

However, even without being able to ascribe a consistent conscious intent behind the utilization of the discourses, in the following chapters I will outline the impact of these discourses. I speculate there that the influence of these media tropes influences the textual archive – and as such policies and procedures related to mental health services – as much as the archive impacts on the perceptions of the general public.

4.8 Preliminary Discussion

To understand how the discourses interact with one another, and where the various documents fall in terms of strength of discursive presence, the following figure is presented.

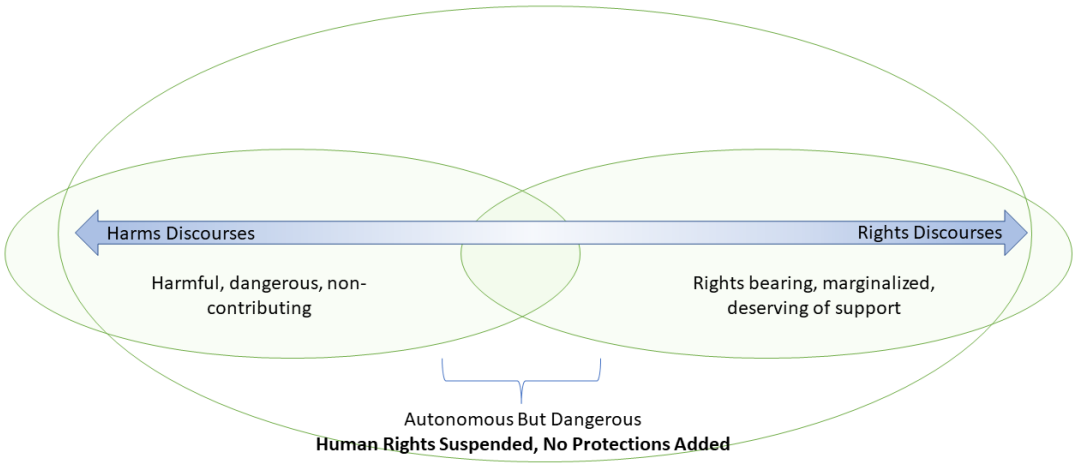


Figure 4.3 The Rights-Harm Continuum

Figure 4.3 represents the interactions between the two macro-discourses that were identified in the textual archive. In this models, the intensity of colour indicates strength/purity of discourse. Within the smaller ovals, the traits of people with mental health problems, within each discourse, are described. There is some notable overlap between the identities formed between the two discourses. The strategy falls here, offset slightly to indicate that it contributes more to the Harms-Paternalist Discourses than to Rights-Autonomy Discourses.

This central zone of overlap indicates a middle zone, in which a unique confluence of discourses, in which individuals with mental health problems are both “vulnerable” but also “autonomous”. It is in this zone (discussed in the next section), where you get the most overlap between elements of the discourses. In fact, one witnesses almost a trading of traits between the two discourses… in which the trait of autonomy, for example, normally associated with the Rights-Autonomy Discourse, becomes “co-opted” within the identity formed by Harms-Paternalist Discourses, and becomes a justification for inaction or lack of support for people with mental health problems.

Note that the strength of the identity formed in the area of confluence is amplified. This too is meaningful. Despite a general weakening of identities away from the poles, there is a point in which the formed identities overlap, and the effects of them on individuals are thus amplified.

In this middle zone between discourses, a unique set of identities is formed, which is addressed in section 4.10. In these identities, human rights are suspended, but no further mitigating procedures or policies are enacted.

4.8.1 Discussion: Power Structures in the Documentation

In each case, people with mental health problems are discussed within the documents as if they are people of special concern. They are named as people of special vulnerability who may require special protections. They are separate, as a group, from society as especially vulnerable, until the question of capacity comes up. Then, again, they are returned to the social whole, granted full autonomy as with others. Thus they once again are granted full responsibility for their own actions and are able to consent to situations that may be exploitative or harmful to them.

The archive, especially the Mental Health Strategy, as will be discussed fully in the next Chapter, is especially clear on the sources of authority and power within the mental health system. Power and authority rests with ‘workers’ in the mental health system. Even in advocacy or grassroots texts, power as held by people with lived experience is aspirational. The current textual reality is that power is not held by people with lived experience *in the context of mental health services.* People have minimal choices offered to them within the texts.

4.8.2 The Rights-Harm Continuum, and the Granting or Removal of Rights

A vital part of understanding the discourses lies in the relationship between the discourses and human rights. Individuals with mental health problems are situated in an unusual and unique place within society. They are

simultaneously vulnerable to abuse (as described in Chapter 2), and also prone to having their human rights suspended on the basis of their identity as mentally ill (as described above, especially in the Mental Health Act). The justification for their having their rights suspended is their potential risk to themselves and others (again, e.g. mental health act).

Further, the Harms-Paternalist Discourse identified here, is utilized as a justification for the suspension of rights. At the same time, the Rights-Autonomy Discourse is utilized as a way of justifying a lack of responsiveness to abuses of human rights.

4.8.3 Amplification of Discourses

As noted above, an interesting feature of the area of confluence between the discourses is that discourses are muddled. It seems that this space in which the different identities overlap is implicated in the special vulnerability to exploitation that we see. In this space between discourses, we see the potential for traits of discourses that are normally associated with the Rights-Autonomy Discourses, can be co-opted to justify lack of action. Namely here, I speak of the trait of “autonomy”.

The autonomy of individuals with mental health problems is explicitly cited in some documents (for example, statements in the adult safeguarding toolkit, or the Social Work Code of Ethics) as a reason why intervention for individuals with mental health problems is not indicated. Similarly, in this space, the marginality of individuals with mental health problems may provide a reason for their vulnerability to exploitation.

Thus, in this space where discourses overlap, the impact of both sets of discourses may be felt negatively by individuals who are experiencing noncriminal exploitation. And it is here that there is no justification created for action (and indeed, justification for inaction is provided).

4.8.4 Dissenting Voices: The Role of Grassroots Activism

It became very clear through the examination of the archive and the representative texts that the social role/identities described by advocacy organizations and NGOs is distinctly different from that described by government administered health services.

Government administered health services, as exemplified in the Strategy (discussed further in Chapter 5) focuses broadly on the medicalized symptoms of people with mental health problems, their disability, and their contributions or productivity.

Grassroots documents, such as those by the SAMH, tend to disregard these discourses virtually entirely. They focus on individual choice, and strikingly, on the rights of the people accessing service in a very direct way. This will be discussed in further detail in Chapter 6.

4.8.4.1 The Discourses and the Advocacy Community

The Rights-Autonomy Discourse is, perhaps naturally, prevalent within the documentation related to the advocacy community. Here, the motivation for the presence is clearer. In this case, it would appear that the deployment of the Rights-Autonomy Discourses are both intentional and strategic. In this sense, it becomes more obvious that they are used to stand in opposition to a deeply engrained Harms-Paternalist Discourse.

At this point, I would argue that, while it is more difficult to trace a temporal origin of the Harms-Paternalist Discourses, as they are deeply embedded in cultural and social attitudes about mental health problems that span generations, it is easier to trace the origin of Rights-Autonomy Discourses, at least as they have been strategically deployed, to advocacy movements.

This relationship between the discourses is important. If one takes this argument of the origin of Rights-Autonomy Discourses to be true, then it is the case that the Rights-Autonomy Discourse by design exists in opposition to the Harms-Paternalist Discourses. This in turn provides context for the

fact that the two discourses, though they exist side by side within the archive, are incompatible with one another. It explains, in part at least, the unbridgeable gulf that exists between the two.

The advocacy community, broadly speaking, has three primary audiences for the documentation that I analysed for this study. First, people who use mental health services. Second, service providers. Third, general society.

The intended effect of discourses for service users is to make individuals aware of their own rights and values within the existing system. This is in order to motivate individuals to ask questions and pursue their own rights. There is often a tacit (and at times explicit) understanding that the service providers will not necessarily act to protect service users' rights without prompting from the user.

The intended effect of discourses aimed at service users is, again, to create awareness of the rights of people with mental health problems, to counter stigma (e.g. the messages within the harm narrative) and thus to motivate service providers to increase awareness of their own actions with regards to the rights of service users. In effect, the intended effect is to create pressure on service providers to abide by their legal obligations towards human rights of people with mental health problems, and to resist the unconscious biases and effects of stigma.

Finally, the intended effect of messaging toward broader society is also to create awareness of the rights of persons with mental health problems. The reduction of stigmatizing messaging is intended to increase the participation of people with mental health problems in society, and to reduce the abuse (and exploitation) that persons with mental health problems face.

4.8.4.2 Othering

As I reviewed the archive again to find confirming and disconfirming examples of the discourses, another theme emerged that warrants mention here: Othering. Othering is an intrinsic part of the Harms-Paternalist

Discourse, and even those texts that romanticize mental health problems are othering, and thus marginalizing. The marginalization of people with mental health problems has the potential to actually enhance their vulnerability to abuse and exploitation.

Othering can be used to describe how a group, usually a minority group, is identified as “other”, alien to the rest of society and is thus marginalized (Modood & Thompson, 2022). Othering entails the formation of identities for the Other, and these identities are used to ascribe negative attributes to members of a minority group, who in turn are unable to easily replace that identity (Madood & Thompson, 2022) with more positive descriptors or attributes. Naturally, there is a long and complicated history of the othering of people with mental health problems (Kamens, 2019). The “othering” of people can often be understood as a tool for dominating (Fine, 1994) or subjugating. Thus, “othering” is about power as much as anything else.

Consensus in marginality literature is that the marginalization of a group occurs when a group is relegated to without the centre (Granger, 2013). This is often taken to mean that those individuals or groups who are marginalized are seen by society to be lesser than in some way – that they are lacking. However, it can entail any perception that groups and individuals are different. These differences can be used to intentionally exclude and exploit (Goodin, 2003), however, it can also be a reason for overlooking groups as well (Goodin, 2003), or excluding them from certain movements.

Thus, when examining the status of people with mental health problems as a group, their “othering” could be a factor in why the uptake of rights-based and other inclusive treatment designs in mental health services has been slow (Holltum, 2016). That is, the othering of people with mental health problems provides less pressure on people in power to make important changes to policy and service design.

4.9 Identities Created Through the Intersection of Discourses

As previously noted, a key feature of the discourses in the archive is the way in which they intersect with one another – or rather, fail to. The disparity between the two main discourses creates a space into which numerous problems fall, including exploitation.

Within this space between discourses, are identities which contain internal inconsistencies. I discuss these identities, and their effects, in this section.

In order to understand the relationship between the different documents and the identities formed, the Rights-Autonomy continuum diagram is presented here in more detail, indicating where this analysis found each document falls in terms of strength of identity formation. In this diagram, there is also an indication of which groups seem to hold the most power and authority in that discursively created space.

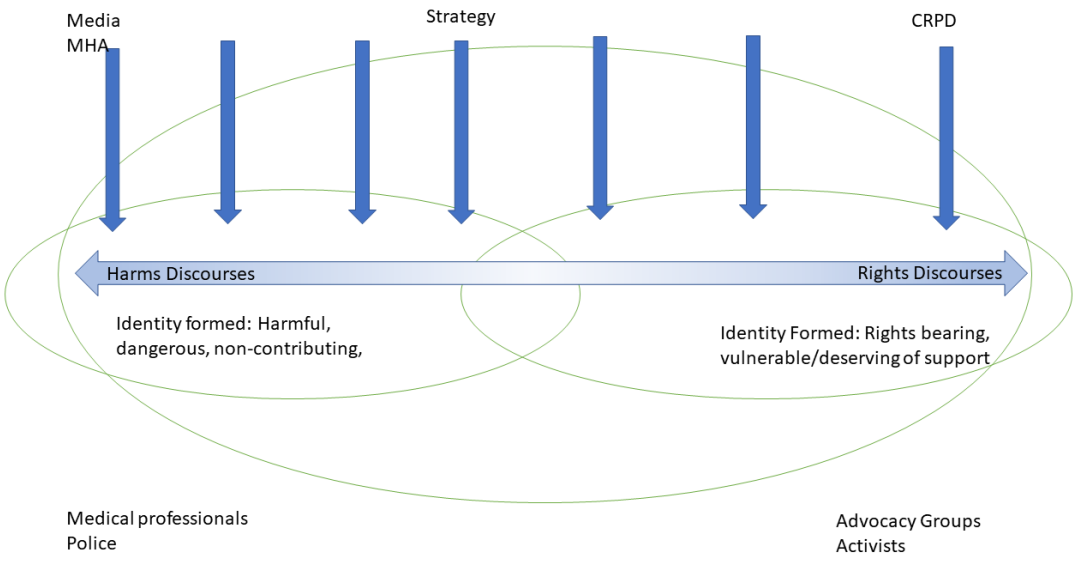


Figure 4.4 Identify Formation

This model indicates where key documents fall in terms of identity formation, as well as which groups hold power.

4.9.1 Vulnerable, But not Vulnerable Enough

The intention of the initial analysis was to focus on how abuse and exploitation was framed in the "official" documentation guiding relevant professions in Scotland. As described in the Chapter 3, in discourse analysis, what is unsaid is as important as what is said. In this case, it became clear that the unsaid was indeed significant: Many documents in the archive were read for reference to abuse, exploitation, human rights and duties. The analysis above only shares those documents found to have reference at all that had specific relevance to the research question.

Abuse and exploitation are framed as issues for people who lack capacity. People with mental health problems are indeed vulnerable, and acknowledged as such in various places through the documentation. Further, each of the professional bodies examined explicitly states or alludes to a firm commitment to protection and support of vulnerable individuals.

That said, unless a mental health problem is deemed to interfere with an individual's capacity to make an informed decision on a specific issue, then there is no legal basis for action on the part of the professions. It is explicitly stated that specific action may in fact be an infringement on an individual's rights.

However, it needs to be noted that in these cases where actions are described, they tend to be such actions as reporting to appropriate authorities – e.g. courts, police etc. Thus, the defined actions that can be taken by the named authorities centre around cases of a) criminal activities (especially where a third party may be at risk) or b) lack of capacity for a specific case. Otherwise, professionals are enjoined to offer nonspecified "support".

This is exemplified by this statement within the Adult Safeguarding Toolkit by the British Medical Association:

> *Where a health professional believes an adult with capacity is at risk of harm, but they refuse assistance, health*

> *professionals should ordinarily respect this decision but keep an accurate and contemporaneous record of the support offered and the reasons for refusal. Such decisions should also be kept under review and ongoing support should be offered (2020, p. 24).*

When facing instances other than clear criminality or lack of capacity, the guidance quickly fades to nonspecific, vague appeals to broad principles and commitments to rights and protection from harm. Thus it could be concluded that for people who are vulnerable to abuse and exploitation due to their mental health problem, the only prescribed actions are those outlined in laws related to specific crimes, or to legal capacity.

Thus, while people with mental health problems who retain capacity – and the threshold for this is high - are vulnerable, there are no prescribed actions for professionals who otherwise generally claim concern for their rights and protections.

This occurs because the focus of the guidance seems to remain on legal frameworks. Any principles or standards of practice that exist beyond legal frameworks appear to lack clear directives. Therefore, as it stands, an identity of people with mental health problems is formed, which is that they are vulnerable to abuses, but not vulnerable enough to warrant special protections.

4.9.2 Autonomous But Dangerous

Thus another identity that is formed by the discourses is that of an individual who is autonomous enough to make mistakes, but dangerous enough that their rights may be suspended. This is exemplified by tensions between two documents: First, within the Adult Safeguarding Toolkit (2020) wherein individuals who are otherwise “at risk” individuals must be allowed *the right* to make decisions that may otherwise be considered harmful. Secondly, the Mental Health Act, wherein individuals are assumed to be at potential risk to

others, and thus may have numerous rights suspended in the name of protection of self or others.

To be autonomous but dangerous means, as described in the texts, is to be autonomous enough to engage in behaviours that may be harmful to oneself, without intervention. That is, one has the right to make decisions that are harmful to self in a number of ways, especially when the harm is *external*. As described in the Toolkit, for example, engaging in harmful relationships is allowed, and this might encompass exploitative relationships. However, there is no corresponding right to be danger to oneself within the parameters of the mental health problems one may be experiencing, as per the Mental Health Act. Thus harm to oneself in terms of poor relationships is allowable, but harm to oneself due to mental illness symptoms (which might manifest as suicidality, self-harming behaviours such as cutting, or even choosing not to stay on prescribed medications) might be enough to trigger action under the mental health act “For the protection of the patient”. This dichotomy seems to indicate that people with mental illness must be protected from themselves, but strikingly, not be protected from the actions of *others.*

4.10 Chapter Conclusions and Next Steps

In this Chapter, the documentary archive was analyzed with the objective of addressing specifically, Research Questions 1 & 2: How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental health problems? How are mental health service providers represented in this relationship?

To this end, 10 representative documents were selected from a larger collated archive. These documents were examined for content related to “exploitation”, especially noncriminal exploitation. After this, a critical discourse analysis was conducted to assess for themes related to the experiences of individuals who use mental health services, especially experiences that might relate to or inform abusive lived circumstances.

The major finding of this analysis was that there are two major discursive themes that exist within the documentary archive. The Rights-Autonomy discourse and the Harms-Paternalist discourse. These discourses, while existing side by side in most of the individual documents, also seem to act in opposition to one another. Further, they contribute to the formation of identities for people with mental health problems. These identities further have internal inconsistencies.

As detailed in this Chapter, an analysis of the documentary archive of mental health services in Scotland resulted in the conclusion that there was no direct content regarding abuse and exploitation of people with mental health problems. Analysis of the texts uncovered no direct discourses or textual examples that addressed exploitation of people with mental health problems. Further, it did not uncover any textual fragments or discourses that could be described as concerned with the precise issue of exploitation. The analysis of exploitation thus was focused on the relationship between vulnerability and the risk of exploitation and abuse.

However, analysis did reveal two conflicting and co-existing discursive threads that seemed to form major themes underpinning and 'weaving' through much of the archive. These two discursive strands are named in this thesis as the Rights-Autonomy and Harms-Paternalist discourses. Upon initial analysis of these themes, it was evident that they are incompatible with one another: That there was strong potential for them to create scenarios in mental health service practice that resulted in diametrically opposing values and imperatives weighing on the same set of circumstances. This final point is addressed in detail in Chapter 6. At the same time, these discourses have the potential to situate individuals – both mental health service users and service providers - in an uncomfortable position within this gap. The identity formed by the archive and imposed on the users of services is variably that either individuals are dangerous (to others or to their own wellbeing), unable to function, vulnerable and requiring assistance; or alternatively, that they are worthy of rights and full participation in society, including the right to make

mistakes and bad judgments which may cause themselves harm, and that they may be “vulnerable”. (These are outlined in Chapter 4). The nuances of these tensions between the discourses, especially in terms of the tensions between the concepts of “harm to self” (either in a self-violent way in one discourse or in the manner of poor use of judgment in the other discourse), as well as the overlapping use of concepts of “vulnerability” are further dissected in Chapter 6.

Upon identification of the existence of both the gap (or ‘silence’), and of these themes, it was apparent that there is no actionable direction or guidance for service providers that exists within the archive on the subject of exploitation. As such, there are no clear answers per se regarding what could or should be done with issues of exploitation and abuse of people with mental health problems, especially for people who work in the field of mental health service provision. In that sense, the initial goal of the research – to uncover what guidance existed – ended there.

I argue that this provides an answer to RQ1 and RQ2. This is provided firstly by outlining how society, and mental health services, situate the identities of people with mental health problems. Secondly, it provides information about how mental health services communicate with those who use services.

The next step taken in the research (described in Chapter 5) was to attempt to gain a further understanding of how the discourses that did exist might impact upon the central research questions, most especially Research Question 4: Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation? Given the analysis to date, I questioned what might be possible in terms of service provision given the existence of these two discursive strands (namely, the Rights-Autonomy strand and the Harms-Paternalist strand) In other words, while the analysis revealed what actions the discourses exclude, I further wished to understand what actions and identities are enabled. This was especially relevant it seemed, given the changes to practice that are occurring and anticipated with a shift in focus towards rights-based mental

health service in Scotland (Mental Welfare Commission for Scotland, 2015). The question thus can be framed: Do the discourses as they exist allow for the possibility of change towards rights-based mental health services? As such, the research turned to *The Mental Health Strategy of Scotland 2017-2027*. As described in Chapters 3 and 4, this document was the initial focal point from which the archive was gathered; the textual exemplar (Palinkas, et al., 2015). This document provides the most direct indication of the intentions of the mental health service policy drivers at the upper levels of policy development: Arguably, as it is a strategic document meant to provide policy direction to all government-commissioned mental health services in Scotland, it is the most direct indication of how policy leaders at the upper levels of authority view the role, position and mandate of mental health services in Scotland. Similarly, it can provide important insights into how they view the users and deliverers of these services.

In this next phase of this study, the Strategy is analysed. First independently and second to assess for the presence of the Rights-Autonomy and Harms-Paternalist discourses identified in the textual archive.

Chapter 5 Critical Analysis of Scotland's Mental Health Strategy (2017-2027)

A focused analysis of Scotland's Mental Health Strategy 2017-2027 [hereafter referred to as "the Strategy" for simplicity] was conducted after the analysis described in Chapter 4. This analysis was conducted with the purpose of examining how the Mental Health Strategy 2017-2027 [Scotland] reflects and enhances specific discourses evident in the contemporaneous document archive; and what does it offer in terms of its stated intention of moving those discourses toward improved human rights of people with mental health problems. Does it provide a framework to understand how to meet the needs of people with mental illness who are embroiled in exploitative situations? To what extent does the Strategy address the issues it purports to address? To what extent does it move forward the rights of people with mental illness? Does it in any way address or attempt to mitigate the gap between discourses uncovered in the initial analysis? These questions were designed to meet the aim of answering Research Question 4: Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation?

The analysis of the Strategy resulted in the conclusion that while it contains numerous references to Rights-Autonomy Discourses, it contains extensive commitments and appeal to the Harms-Paternalist discourse. Notably, the Harms-Paternalist discourse is associated with more direct and concrete prescribed actions, and to some appearances is better resourced (e.g. financially) than the Rights-Autonomy discourse.

Thus, not only is the tension uncovered in the archive fully represented in the Strategy, but so far as active statements containing concrete directives, the Harms-Paternalist discourses are more fully resourced (as will be discussed below). On numerous re-reads of the Strategy, there appears to be no discursive attempt to mitigate, acknowledge, or provide a way of overcoming the incompatible tension between the Rights-Autonomy and Harm-Paternalist discourses. This could indicate ignorance of the tension, or more likely (as

will be discussed further in detail in Chapter 6) a failure to address a well-known issue and reluctance to shift power differentials away from traditional medical models toward person centered and person directed service provision.

The strategy thus is insufficient to move mental health services forward towards rights-based mental health: It will not resolve the issues and gaps apparent in the policies that apply to people with mental health problems.

5.1 Analytic Framework

Given the nature of the two Discourses and given the stated intention of the Strategy, the central concern of this analysis is: To examine how the Mental Health Strategy 2017-2027 [Scotland] reflects and enhances specific discourses evident in the contemporaneous document archive, and what does it offer in terms of its stated intention of moving those discourses toward improved human rights of people with health problems.

The mental health strategy of Scotland was also analyzed in detail to gain insights into how abuse and exploitation may be addressed, and to analyze the document overall to gain an understanding of how in general people with mental health problems are framed as recipients of service. In a general sense, the document was analyzed for how people with mental health problems are “talked about” – what role in society are they “allowed”.

For the first pass of analysis, guiding questions (Rapley, 2011) are: What authority does the Strategy appeal to, for example by the citations the text uses; What source of knowledge and evidence does it cite; What are the authoritative sources of knowledge it references; Who are the experts as presented; How are subjects – e.g. patients – referenced; What value judgments may be embedded in choice of language?;What relevant voices are not drawn on in this text?; What is the defined “problem” in the text; Who is presenting the “solution” to the problem; and how are specific identities produced, sustained and/or negotiated within texts? (Rapley, 2011).

5.2 Analysis and Discussions

5.2.1 General Description of the Document:

While the intention of Strategy is in part to communicate the intentions of upper-level policy makers to a broad audience, the Strategy is primarily written for an audience of professionally employed persons and especially (lower level) policy makers in mental health services.

To reach this conclusion, a basic test of readability was applied. While a concrete measurement such as this may appear to be an odd fit with a qualitative critical methodology, the focus of discourse analysis is not only in the meaning of the text, but in the ways in which the texts are delivered. If meaning is co-constructed, as is the stance taken in this study, then one should analyse the accessibility of the texts. If a text is made inaccessible to some, it bears noting. As such, as a measure of the accessibility of the document in this case, it was analysed on the Flesch Reading Ease scale (using a simple strategy of cutting and pasting the text into a word document, and allowing the Word software to analyse the text). The result of the software analysis was that the readability rating was 45.5, which puts it at a level of “difficult to read, best understood by college graduates”. There are numerous instances of textual fragments that are jargonistic or technically oriented: There are phrases used that carry specific meaning that are not defined (there is no glossary for example). This indicates that it is not necessarily intended to communicate meaningful information to a general audience but rather to communicate to individuals who are deeply familiar with mental health policy, practice and the structure of mental health services. This indicates in part the intended audience is not necessarily mental health service users, as a document that was intended to be broadly understood by a cross-section of society would be written with less jargon and at a more easily understood reading level.

Table 5.1 Examples of jargonistic or meaning-laden text fragments

Text Fragment	Pg.	Understood Meaning/Interpretation
"co-occurring… illness" "severe and enduring.."	9 9	These phrases convey very specific meaning, the nuances of which might not likely be fully appreciated by laypersons
"Help create a Fairer Scotland"	11	Specific reference to another government Action Plan. Note there are many such references to external strategies, plans and documents.
"…right of every individual to the highest attainable standard of physical and mental health"	12	Specific reference to UN conventions
"Children and young people involved in and/or at risk of offending may have mental health problems but not necessarily a mental illness"	16	Distinction between mental health problem and mental illness is not clearly understandable to many and is not clarified in the document.
"… help in delivering against the right to the highest attainable standard of health, as well as delivering on non-discrimination and equality in a human-rights based approach, and helping to achieve both parity of esteem and treatment"	21	Jargon laden. Note that this is a direct reference to another external document re. Urgent Care in Scotland.

The introduction of the document is written by Maureen Watt MSP, Minister for Mental Health [at the time of publication of the Strategy], indicating the level of authority that is involved. Namely, the Strategy is imbued with the authority of government officials.

The ***Summary of Actions*** has 40 "actions" to be taken under the strategy, divided into 5 categories being;

- Prevention and early intervention
- Access to treatment and joined-up, accessible services
- The physical wellbeing of people with mental health problems
- Rights, information use and planning
- Data and measurement (p.1)

These action points vary in terms of specificity, ranging from specific plans to infuse funding amounts (i.e. "£35 million for 800 additional mental health workers in those key settings" p.4) to vague commitments to "support" ("Support an increase in support…" p. 4).

Following this is the "Our Vision" statement (p.1) (who "our" refers to is not defined here but it is presumed to be the Scottish Government, as this is who is credited as author, and due to Ms. Watt's statement referring to "we"). The Vision statement is quite detailed and extensive, covering all aspects of the Strategy. This speaks to the question of "who is given authority" as addressed below.

5.2.2 Analysis of Contents

In this section, I will outline the analysis conducted on the document using Rapley (2011) as a framework (as described in section 3.5). Prior to this analysis, however, I present the notes on the impressions that were made on the initial read-throughs of the documents.

5.2.2.1 General Impressions

This subsection summarizes the initial impressions the text made during the initial read-through.

There is an overall emphasis on economic factors within the document. For example: The productivity of people with mental health problems or difficulties, which is captured in numerous ways. Firstly, we see it represented in the emphasis on employment or employability of people with mental health problems, and that not having a job is equated with “biggest” inequality created by poor mental health.

> *“Not having a job is the single biggest inequality that people with mental health problems can face. We will use our new employability powers to work across health and employability services to support people with mental health problems to stay in work and to support people to get back into work.” (p. 9)*

Economic factors are also related to funding issues. The phrase “efficiency” is regularly used and is understood as code for financial efficiency.

Expertise is held by GPs and mental health specialists. There is little voice given to the perspectives of people with lived experience of mental health problems, mental health problems, or users of mental health services. Specialist care is emphasized as best and the safest – i.e. in statements that specialist care is needed in order to not cause further harm to persons with mental health problems/difficulties.

Recovery orientation of services is mentioned multiple times but a commitment to it is not explicitly stated. That is, at no point is there a statement that provision of recovery-oriented services is a strategic goal. Rather “recovery-oriented services” is a phrase used to describe current services. For example:

The Scottish Government will consider how its support to the Third Sector can help build capacity in local areas for effective partnerships between Third Sector bodies, between the Third Sector and public authorities, a strong mental health Third Sector Interface, and to support continuing development of recovery-oriented services. (p. 22)

or

Every contact is an opportunity to promote health (both physical and mental), and to take a recovery-oriented approach (p. 35)

These phrases imply that the authors believe – and assert - that current services are at least to some extent recovery-oriented.

Notably, there are references to the justice system as a “key” element of mental health care. Thus the Strategy reinforces the connection between mental health problems and the judiciary system.

Other statements regarding the relationship between services and the law are revealing, such as here:

The implementation of mental health law will promote the realization of the human rights of people experiencing mental health problems. (p. 33).

There is little further explanation of the link between mental health law, and more specifically the *implementation* of mental health law, and the promotion of human rights.

Consistent with analysis of previous documents, there is a repetitive use of term “support” as a prescribed action, with little expansion or detail:

Support an increase in support for the mental health needs of young offenders, including on issues such as trauma and bereavement (p.4)

There is a heavy emphasis on physical and mental health care parity but subtle differences in language applied to each. Non-discrimination is often linked to parity of physical/mental health services – that is, discrimination is contextualized in terms of the importance of access to mental health services as compared to physical health services. This reinforces the connection between medical health care services as appropriate for mental health.

> *Too often, people with mental health needs experience longer waits in out of hours services than people with physical health needs. This is unacceptable and is a basic issue of parity in healthcare. Addressing it will help in delivering against the right to the highest attainable standard of health, as well as delivering on non-discrimination and equality in a human rights-based approach, and helping to achieve both parity of esteem and treatment (p. 21)*

There are numerous references to multiple outside documents, plans and programs: I would call it a “web” or “constellation” of services and policies that impact on the lives of people with mental health problems. The linkages reflect other strategic documents produced for or by the Scottish Government, the United Nations (as seen in the above quote, which contains an unattributed reference to language used by the UN), NHS England, The Royal College of Psychiatrists, The Academy of Medical Royal Colleges, Police Scotland, and the World Health Organisation. Further there are numerous references to various human rights frameworks and laws that are relevant to people with mental health problems and with disabilities.

The services and programs that are available to the users. Strands of policies make up a complex web of services and programs that are available directly to service providers via policies and practice guidelines. Service users experience the policies and services as mediated by the service providers. Thus, their experience of the services is entirely though their experience or relationships with the service providers.

In general, service users would be expected to have little to no direct access to these policies and strategies being followed by the service providers. Service providers are thereby the connecting point or mediators between service users and the policies and procedures that underlie the services they use, and often rely on. The service users' experience of strategy and policy is through their interactions with service providers.

Finally, it bears noting that the Strategy engages the use of a phrase "Ask Once and Get Help Fast", which is repeated throughout the document as a slogan. Support for this appears to take the form of an outline of plans directed towards enhancing existing resources such that they are better equipped to deal with mental health problems, including NHS24, A&E services, GP services, police services, and Third Sector resources and services.

5.2.2.2 Word Cloud

As with the previous Chapter, it is a worthwhile exercise to generate a word frequency cloud, to assess the commonality of words, to assist with understanding the general tone and use of language, within the context of the broader analysis. The repetitiveness and thus emphasis of words can create a sense of importance to the reader, as well as give a sense of major themes and topics of the text (McNaught & Lam, 2010). It can also be useful to give indications of the standpoints of the authors (McNaught & Lam, 2010). With this in mind, whilst some of the most commonly used words in the Strategy are of the sort one would expect ("Person" "mental" "health" "services" "Scotland"), others are more illuminating. There appears to be an emphasis on youth and young people, which is supported by the analysis. As will be indicated (see Table 5.3 below), there are numerous interventions targeting early intervention, which appears to be interpreted by the Strategy as "intervention among young people".

Another word that stands out is "physical", which is borne out in analysis, in that the Strategy emphasizes the importance of mental health care being "on a par" with physical health care. It is also the result of numerous references

to physical health disparities among people with mental health disorders. That is, the Strategy references the increased presence of physical health disorders among people with mental health disorders, and makes some mention of the marginalizing effects of this phenomenon.

Words like “integration”; “training”; “education”; “development” speak to the Strategy’s content around using the resource that are available, more effectively.

The words “right” and “rights” appear as frequent words as well. Conversely, while “justice” appears, it is entirely used in the context of the criminal justice system, rather than the ethical concept of justice for people with mental health issues.

While the word “partners” is present with some degree of frequency, this is not used to reference people with mental health disorders, but rather is in reference to other organizations who act in partnership with government-run mental health services.

Figure 5.1 Word cloud of the Strategy

(This word cloud was generated using NVivo software)

5.2.2.3 Sources of Authority & Knowledge

In this document, knowledge based on “evidence” is heavily prioritized. Evidence tends to be used in such a context as referring to positivist knowledge, based on academic research, which of course can generally only be produced by individuals who are affiliated with a research institution (e.g. a University, research centre, and so on). This document specifies that interventions (or processes) should be based on “evidence”. To emphasize, *evidence* in this context appears to be in reference to knowledge produced and published in an academic sense, and does not explicitly include knowledge produced by anecdote, lived experience, and so on. There is no discernable reference to knowledge or guidance from individuals with lived experiences as services users in this text, while evidence from specific sources is directly identified: Namely from the fields of psychology and medicine. For example,

> *… where a child would not be diagnosed with a mental illness, but could be helped by a psychologically-informed approach (P. 14)*

Or

> *improve provision of psychological therapy services and help meet set treatment targets…. Develop more accessible psychological self-help resources (P.5)*

Tokens embedded within the text that reinforces the importance of “evidence” include the repeated use of phrases such as “Good data”; “Best Practice”; “Clinical Guidelines”; and “rapid, modern, evidence-based services”.

As discussed in Chapter 2, “evidence” is treated with privilege in society. Health care professionals, especially Medical Practitioners receive authority from their access to evidence (Swerdfarger, 2016). The heavy reliance on expertise in the Strategy privileges the holders of specialized knowledge within the system. It does not leave space for people with lived experience as holders of specialized knowledge, which is consistent with the criticisms of

psychiatry as outlined in Chapter 2 (see for example Swerdfarger, 2016). ‘Evidence’ thus emerged as a theme from the document and will be discussed further below. This is in contrast to discourses that exist within the archive - notably in texts that are advocacy oriented - that prioritize the expertise held by service users, persons with lived experience and their families (as was described in Chapter 4).

5.2.2.4 Defined Roles: Experts & Recipients of Service

The text engages in appeal to experts and to expertise repeatedly. Individuals who are cited as “experts” who will variously guide programming or deliver interventions are named: NHS Board staff, primary care practitioners, councils and third sector organizations, health visitors, midwives, school nurses, people who work in schools, Police Scotland, emergency departments, specialist staff, primary care, and GPs.

As with before, note the lack of individuals with lived experience, or experience as service users named as experts.

People who are defined as targets for the strategy, or recipients of care, are defined as: “people with mental health condition”; Mental illness; and Mental difficulties. The roles that are defined for such individuals in this text are that of recipients of services from experts, and individuals who can and should be productive within society. Services are intended to mitigate the impact of mental illness to participate in society, particularly within an economic context.

As noted elsewhere in the archive, there is a strong link identified in the Strategy between the discursively constructed relationship between the concepts of the criminal justice system (here defined as Police Scotland) and people with mental health problems. The continued, frequent, and (most importantly) uncritically expressed relationship between people with mental health problems and Police expresses a tacit identity for people with mental health problems – and this is fully inclusive of children and youth with mental health problems or illness (as demonstrated). This identity, as discussed in

Chapter 4, is one of high risk of involvement with the judiciary and is consistent with the Harm-Paternalist discourse. When one indicates that a natural “service provider” for people – even youth – with mental health problems is in fact the police, this entrenches a relationship and social expectation. That police are seen as the natural intervenors when a person or young person is in mental crisis is fully entrenched here in the strategy. Due to the high number of references to the criminal justice system and the police, these textual fragments and their contexts are presented here in a table (Table 5.2), both for ease of communication and to appreciate the entrenchment of the concept.

Table 5.2 Reference to Police/Criminal Justice system

Textual Fragments	Context	Analysis
We will support the justice system to work effectively with local partners to improve outcomes for people with mental health problems. We will facilitate work with Police Scotland and Integration Authorities to ensure that people with mental health problems or who are in distress are supported. We will work with the Scottish Prison Service and partners to improve the mental health of prisoners, including supporting young offenders (p.8)	Vision Statement	The justice system and police Scotland are centrally placed within the vision statement. This is not only in reference to prisoners but also a tacit acknowledgment that police are often first called to situations in which people are experiencing a mental health crisis (citation). This can be construed as a reflection of social norms.
There are many opportunities to develop and improve actions that promote good mental health for	Mental Health and The Justice System	Note the reference to people who are not yet involved in the justice system but who “contact the police in distress”.

people who come into contact with the justice system as a result of their offending behaviour, or who contact the police in distress. (p.18)		Does not mention that police are often contacted by others to intervene with people who are in distress, or that police are often sent when emergency services are called on behalf of someone in distress (citation).
Police Scotland has highlighted that it will work with partners to intervene early to address high impact issues such as mental health problems.	Mental Health and the Justice System	It is presented as natural that Police Scotland will be “early intervenors” in mental health problems.

5.2.2.5 Absent Voices

Relevant individuals whose perspectives are not represented in this text are: People with lived experience *as expert*; and families. Nowhere in the document are people with mental health problems defined as experts in their own care, except for passing references to “person-centred care” (pp. 2, 7, 37), which, if one is familiar with the phrase, entails at least the principle that unique individual needs ought to be respected (World Health Organisation, 2021). This however is not direct reference to the expertise of the service user, nor does it in any meaningful way centralize the user voice in the text of the document.

References to “recovery-oriented care” are present but poorly explicated (see for example, pp.22, 23, 35.) This is despite prevalence of recovery orientation elsewhere within the archive and the importance of recovery-oriented care being emphasized in the literature (as discussed in Chapter 2. See for example Pilgrim & McCranie, 2013). Given that recovery orientation is often characterized as prioritizing the perspectives of service users (Tilley & Cowan, 2011), the weakness of recovery orientation is notable and can be characterized as further exacerbating the “missing voice” of the service user.

The phrase “recovery” also appears in the context of “supporting people to manage their own mental health” (p. 35) as well as in “recovery” from mental health problems. In these instances, there could be an implication that recovery is something inherent to the individual, and that services are there to support. The Strategy states

> *“The importance of the approach and culture of staff in public services…. Cannot be overstated. Every contact is an opportunity to promote health… and to take a recovery-oriented approach”. (p.35)*

This statement follows a statement regarding the “sustainability” of mental health services. Together, this reinforces the impression that the authors of the document believe recovery-oriented approaches are as much about downloading responsibility for health onto individuals and thus relieving pressures on services, as it is about the control of individuals over their own health.

These references toward recovery are ambiguous at best, and do not imply the depth of meaning that the “recovery orientation” requires. The recovery orientation to mental health emphasizes personal recovery over clinical recovery (Williams et al., 2012). This personal recovery is characterized by living a life of satisfaction and hope, despite the presence of disease or symptoms (Anthony, 1993). The emphasis of recovery-oriented care therefore is not on the reduction of symptoms, but on supporting the person in attaining fulfilment and maintaining hope (Williams et al., 2012). While of course this is not directly incompatible with medically oriented care that is focused on symptom reduction, the adoption of a recovery orientation as foundational to a health service leads to different emphases on which services should be prioritized. Given that personal recovery is very different from clinical recovery (Deegan, 2002; Williams et al., 2012), a recovery orientation will naturally require emphasizing a broad range of supports. This may include medical and primary care, but primary care would certainly not be centralized in a truly recovery-oriented system (Williams et al., 2012).

Thus the skewed reference of “recovery oriented care” as something that is relevant to the sustainability of services is meaningful, particularly in light of the overall emphasis on primary care in the Strategy.

5.2.2.6 The Defined Problem

The text states that mental health services require a “sea change”. This seems on the face to express a principle that services are inadequate as they are and require fundamental changes to perspective and policy in order to become fit for purpose. The solutions that are proposed however, do not in fact encompass such a fundamental shift, and in fact, defining the proposed changes as a “sea change” is deleterious to further attempts to fundamentally change how mental health services are conducted in Scotland.

Within the text, the problem is defined as mental health care not having “parity” with “physical health care” [a comparison which reinforces the associations between mental health and medical care]. The text states that treatment is not received by service users fast enough.

Within the text is the following statement:

> *“We want to create a Scotland where all stigma and discrimination related to mental health is challenged, and our collective understanding of how to prevent and treat mental health problems is increased. We want to see a nation where mental healthcare is person-centred and recognizes the life-changing benefits of fast, effective treatment. We want a Scotland where we act on the knowledge that failing to recognize, prioritise and treat mental health problems costs not only our economy, but harms individuals and communities. In short, we share the ambition that you should only have to ask once to get help fast.” [p. 1 Quote from Maureen Watt minister for mental health]*

Who ”we” encompasses is not clearly defined within the text, but given that the quote is from the minister for mental health, it can be inferred that this is a statement coming from the government.

Thus, the “defined problem” within the text, as presented by the authors, can be summarized such: *Mental health services in their current state are under-resourced, as evidenced by lack of parity of treatment with physical health; and inefficient (“ask once get help fast”).*

Note that the defined problem does not include the numerous issues that were identified within the consultation processes that occurred during the development phase of the Strategy. This will be addressed in more detail in Chapter 6. These suggestions included, among many other things, the need to improve human rights within mental health services, and to address inequality at the community level (Scottish Government, 2016). While this is addressed in further detail in the next chapter, at this point it is relevant to note that the fact that these suggestions did not make it into the final draft of the Strategy is telling of what the people who authored the final draft considered to be the “real” issues facing mental health services in Scotland. Thus the defined problem in this context is as much defined by the absence of voices as it is by the presence of those in authority.

5.2.2.7 Proposed Solutions and Solvers

On this subject, the document is quite clear, offering numerous solutions to the issues that are identified. Some solutions are general. However, the document also outlines so-called “ambitions” that are more specifically delineated.

5.2.2.7.1 General Themes

“Ask once and get help fast” is a central theme of the document – this defines an overarching goal of the strategy. This directly targets the proposed issue of rapidity of services. Arguably, offering existing services faster does not represent a “sea change” in most senses of the use of the term.

Solutions presented within the text are: Increasing workforce; “Improving support for” preventative and less intensive services; “Reviewing role of” counselling services in schools; “Testing and evaluating the most effective and sustainable models of supporting mental health in primary care” (p. 3) and “Establishing a bi-annual forum of mental health stakeholders to help guide implementation of actions” (p. 3). Note that who the “stakeholders” are is undefined within this document.

It is notable that through the document there is an emphasis on efficiency of services and treatment. For example:

> *Good data collection requires an underpinning of development and use of digital tools and better use of electronic information: as well as supporting data these can increase efficiency and improve healthcare outcomes in Scotland. (P. 37)*

Again, in reference to the need for a “sea change” the language used within the Strategy is relatively watered down. “Improve support” is not accompanied by a substantial or meaningful definition of “support”, and thus it is unclear how improved support will be achieved, be it in terms of funding, increased workforce, etc. “Reviewing” can be an important first step, but does not come attached to a commitment to expand the role of counselors in schools or to even increase the number of available counselors.

The document offers as a partial solution that “our efforts must deliver on a human-rights based approach, so that people in the most marginalised of situations are prioritized in achieving health” (p.3). Again, this does not offer further detail about how “human rights-based approaches” may be turned into action. And as such, as noted elsewhere, while human rights, recovery oriented and person-centered care are often mentioned, details on how these might be turned into actions are lacking.

5.2.2.7.2 Ambitions:

Table 5.3 (below) summarizes the “Ambitions” and “Related Actions” that are expressed in the Strategy, and identifies the targets of the ambition and notable discursive fragments within the text describing them.

The guiding ambition is identified as:

> *… that we must prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems. (p.1)*

This statement can be interpreted in a few ways. First, obviously, that it identifies an issue of parity, which is mentioned throughout the document. This issue of course has been identified throughout the literature and as such is a commonly acknowledged one within mental health service: That mental health services are simply not resourced to the same level or degree as physical health services (Baker & Kirk-Wade, 2023). With that said, it does entrench the notion at least at a superficial level that mental health and physical health problems are of a kind: That they are both natural members of the family of health care. As has been discussed in Chapter 2, there is an at times contentious debate around the nature of mental health service care and the medicalization of care, which is embedded within society. This statement formalizes and continues the binding of the two systems as one, and doesn’t acknowledge a unique path for mental health services outside of physical health services. The implication seems to be one of two branches of one health care system, one of which deserves ‘equal’ footing to the other. The continued medicalization of mental illness is established as the guiding ambition.

Table 5.3 Analysis of Ambitions in the Strategy

Key Indicator	Ambitions	Related Actions	Identified Groups	Analysis Notes & Notable Discourse Fragments
Prevention and early intervention	• Every child and young person to have appropriate access to emotional and mental well-being support in school. • Appropriate, evidence-based, parenting programmes should be available across Scotland. • Evidence-based interventions to address behavioural and emotional issues in children and young people should be available across Scotland. • Mental health support and treatment for young people involved in offending who have mental health problems should be available across Scotland. • Mental health training for non-mental health staff should be available across health and social care services.	Action 1: Review Personal and Social Education (PSE), the role of pastoral guidance in local authority schools, and services for counselling for children and young people. Action 2: Roll out mental health training for those who support young people in educational settings. Action 3: Commission the development of a Matrix of evidence-based interventions to improve the mental health and wellbeing of children and young people. Action 4: Complete the rollout of national implementation support for targeted parenting programmes for parents of 3- and 4-year olds with conduct disorder by 2019-20. Action 5: Ensure the care pathway includes mental and emotional health and wellbeing, for young people on the edges of, and in, secure care.	Youth	Emphasis on school age and young children in “early intervention” “offending” [criminal system involved] children specifically named “multi-agency pathways” is defined thusly: *build the confidence and capacity of front line staff in non-mental health* *services (such as health visitors, midwives, school nurses and teachers) (p. 18).*

	• Training in first aid approaches for mental health should become as common as physical first aid.	Action 6: Determine and implement the additional support needed for practitioners assessing and managing complex needs among children who present a high risk to themselves or others. Action 7: Support an increase in support for the mental health needs of young offenders, including on issues such as trauma and bereavement. Action 8: Work with partners to develop systems and multi-agency pathways that work in a co-ordinated way to support children"s mental health and wellbeing. Action 9: Support the further development of „Think Positive" to ensure consistent support for students across Scotland Action 10: Support efforts through a refreshed Justice Strategy to help improve mental health outcomes for those in the justice system. Action 11: Complete an evaluation of the Distress Brief Intervention by 2021 and implement the findings from that evaluation	People in justice system Service users of emergency services Rural persons	

		Action 12: Support the further development of the National Rural Mental Health Forum to reflect the unique challenges presented by rural isolation. Action 13: Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them. Action 14: Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services	Service users	
Access to treatment, and joined up accessible services	• Access to the most effective and safe care and treatment for mental health problems should be available across Scotland, meeting the same level of ambition as for physical health problems. • Safe and effective treatment that follows clinical guidelines.	Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.	Workforce/service users	Timely care emphasized Very high level of specificity attached to the resources here. Timeline included. Target numbers are attached.

	• Safe and effective treatment accessed in a timely way. • Services that promote and support recovery-based approaches. • Multi-disciplinary teams in primary care to ensure every GP practice has staff who can support and treat patients with mental health issues. • Appropriate mental health professionals are accessible in Emergency Departments and through other out-of-hours crisis services.	Action 16: Fund the introduction of a Managed Clinical Network to improve the recognition and treatment of perinatal mental health problems Action 17: Fund improved provision of services to treat child and adolescent mental health problems. Action 18: Commission an audit of CAMHS rejected referrals, and act upon its findings Action 19: Commission Lead Clinicians in CAMHS to help develop a protocol for admissions to non-specialist wards for young people with mental health problems Action 20: Scope the required level of highly specialist mental health inpatient services for young people, and act on its findings. Action 21: Improve quality on anticipatory care planning approaches for children and young people leaving the mental health system entirely, and for children and young people transitioning from CAMHS to Adult Mental Health Services	New parents Youth	Highly synced with medical system: GPs, emergency rooms, etc. Economic emphasis on funding in specific locations: namely medical units, police stations and prisons. The actions are not terribly aligned w/ the spirit of the ambitions.

		Action 22: Support development of a digital tool to support young people with eating disorders. Action 23: Test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019. Action 24: Fund work to improve provision of psychological therapy services and help meet set treatment targets. Action 25: Develop more accessible psychological self-help resources and support national rollout of computerised CBT with NHS 24, by 2018. Action 26: Ensure the propagation of best practice for early interventions for first episode psychosis, according to clinical guidelines	Service users	
The physical wellbeing of people with mental health problems	• That premature mortality of people with severe and enduring mental illness is tackled. • That the rate of smoking amongst people with a diagnosed mental health problem should decline at the	Action 27: Test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health diagnosis.	Service users	Synchronicity with physical health issues

	same rate as the rate for the general population. • That the uptake of screening for cancers, amongst people with a diagnosed severe and enduring mental illness, should be the same as the rate for the general population. • That side effects of psychiatric medication are appropriately monitored and, where possible, reduced.	Action 28: Offer opportunities to pilot improved arrangements for dual diagnosis for people with problem substance use and mental health diagnosis. Action 29: Work with partners who provide smoking cessation programmes to target those programmes towards people with mental health problems. Action 30: Ensure equitable provision of screening programmes, so that the take up of physical health screening amongst people with a mental illness diagnosis is as good as the take up by people without a mental illness diagnosis. Action 31: Support the physical activity programme developed by SAMH.	Substance users	
Rights, information use and planning	• That a human-rights based approach is intrinsic to actions to improve mental health. • That legislation related to mental health is fit for purpose. • That people who have experienced mental health problems can be supported back into the workplace. • That people who develop poor mental health are supported to stay	Action 32: Use a rights-based approach in the statutory guidance on the use of mental health legislation. Action 33: Commission a review of whether the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 Act fulfil the needs of people with learning disabilities and	Service users	Neoliberalism States that a rights-based approach will be achieved THROUGH use of “mental health law” (p. 33)

	in work just as they would be with physical health problems	autism, taking forward new legislative measures if necessary. Action 34: Reform Adults With Incapacity (AWI) legislation. Action 35: Work with key stakeholders to better understand Mental Health Officer capacity and demand, and to consider how pressures might be alleviated. Action 36: Work with employers on how they can act to protect and improve mental health, and support employees experiencing poor mental health. Action 37: Explore with others innovative ways of connecting mental health, disability, and employment support in Scotland Action 38: Develop a quality indicator profile in mental health which will include measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely. Action 39: Establish a bi-annual forum of stakeholders to help track progress on the	Adults with incapacity Stakeholders Employers Employment	Reformation of legislation First mention of [external] stakeholders Emphasis on Employment Expertise and measurement (quality indicator profile)

		actions in this Strategy, and to help develop new actions in future years to help meet our ambitions. Action 40: Carry out a full progress review in 2022, the halfway point of the strategy, to ensure that lessons are learnt from actions to that point.	Stakeholders	What is the status of the progress review?

5.2.2.7.3 Related Actions

It is notable that when it comes to the actions that are advocated in the Strategy, there is a range of specificity attached to each of them. Arguably, the actions that are related to current medicalized care of mental illness and themes of criminality and risk are more specific, then actions that are related to themes of human rights, recovery oriented and person centred care.

Arguably, the most specific actions are related to the theme of “Access to treatment, and joined up accessible services”.

As seen in the above table, the relevant “ambitions” related to this theme are:

> *Access to the most effective and safe care and treatment for mental health problems should be available across Scotland, meeting the same level of ambition as for physical health problems.*
>
> *• Safe and effective treatment that follows clinical guidelines.*
>
> *• Safe and effective treatment accessed in a timely way.*
>
> *• Services that promote and support recovery-based approaches.*
>
> *• Multi-disciplinary teams in primary care to ensure every GP practice has staff who can support and treat patients with mental health issues.*
>
> *• Appropriate mental health professionals are accessible in Emergency Departments and through other out-of-hours crisis services. (p.23)*

The actions that are defined within this theme are of the most specific and actionable in the entire document. The most specific action, namely Action 15, is directly related to the medicalized care of mental illness:

> *Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings. (p.23)*

This is relevant to several of the questions of analysis. For instance, one can argue that the level of detail and attention paid to this particular set of actions speaks to the relevance placed on them by the authors of the document.

This set of ambitions and actions is arguably related to the current model of mental health care, and seems to speak the least to ambitious re-structuring or re-visiting of care models. It defines treatment spaces as “A&Es, GP practices, police station custody suites and prisons”. There is a number of new professionals given: 800 new workers in these so called “key settings”. There is an actual funding amount and target of years for spending. No other set of actions contains such a level of detail or specificity as this. Again, without belabouring the point, it bears emphasizing that this reveals much about the authors’ identification of where and how mental health services are to occur.

Notably, actions related to human rights, person-centred or recovery-oriented services generally lack any such detail. For example, as seen in the above table, the action related to the ambition: “That a human-rights based approach is intrinsic to actions to improve mental health” is as follows:

> *“Use a rights-based approach in the statutory guidance on the use of mental health legislation” (p.33).*

Similarly, the sole ambition that names “recovery oriented” care: “Services that promote and support recovery-based approaches” does not actually seem to be attached to any particular corresponding action.

It is for this reason that I argue that the most “resourced” issues are those that are related to medicalized care, criminality, and so on. As discussed below, these themes that are more heavily resourced track onto the Harms-Paternalist discourses.

5.2.2.8 How are specific identities produced, sustained and/or negotiated

The identities of two groups are notable here. First, the identities of service users, and secondly, less obviously, the identities of the service providers.

5.2.2.8.1 The Identities and Roles of Service Users

“People with mental health problems” are identified as a target of intervention by mental health services. Much can and has been said about language around individuals who use mental health services, and/or who have diagnoses of mental illness (Nairn, 2007). The language of “mental health problems” expands the target population beyond individuals who have a specific diagnosis of mental illness, which does help expand the population of individuals who fall under this Strategy. This may help moderate some of the marginalization sustained by identifying them as a unique subpopulation who require special care.

As noted above, there is a recurring emphasis on the “productivity” of people with mental health issues. This indicates a continued commitment to an entrenched notion that the threshold between a problem and an illness exists in the space where a person’s productivity is compromised. That is, when they are no longer able to participate fully in employment, education, or social activities.

There are recurring references to the relationship of people with mental health problems and the criminal justice system, which reinforces the association between them. This, along with the emphasis on productivity, is among the clearest examples of how the “risk” discourse manifests in this text.

People are regularly defined within this text as “vulnerable”. With little exception, this is stated simply as a matter of fact, with no extrapolation or detail into what “vulnerable” means. The term “vulnerable” is used as a descriptor of individuals:

> *… the most vulnerable students (p. 18)*

> *… staff in housing… who may be the first point of contact for the most vulnerable people (p. 21)*

> *… vulnerable children and families (p. 25)*

The one point at which the phrase “vulnerable” receives further definition is regarding young people, as such:

> *… vulnerable children (e.g. those living in poverty, children in care, children in contact with the criminal justice system and children with a learning disability and/or autism) (p. 24)*

There is seeming to be little to no detail given to answer; what are these individuals vulnerable to?

People with mental health problems are also at times considered as having a disability; “disabled people are therefore intrinsic to this strategy” (p. 29). But how they are intrinsic remains undefined, except that they are also a subject of it. The overall identity formed of people with mental health problems then seems to be centered around their relationship with others in society, and their relationship with social structures.

Similarly, the relational aspect of the identities formed herein is reinforced in the identities of experts. As discussed above, expertise is given to physicians, GPs, psychiatrists, psychologists and other employees of the mental health system. Similarly, expertise or authority is granted to Police Scotland. While at points, individuals with mental health problems are cited as people to whom employees should listen as treatment decisions are made…

Where people do not feel welcomed, or do not see themselves represented, it can be hard for them to open up about mental health problems or to believe they will be listened to (p. 21)

[Link Workers] also work with people to optimise their own health, and monitor some chronic condition care plans. This approach will support the delivery of ask once, get help fast (p. 26)

Evidence indicates that where people have the tools to manage their own health – including being supported to do so, such as through social prescribing - then their wellbeing may be improved (p. 35)

The importance of the approach and culture of staff in public services, including, but not limited to, mental health services and other health and social care services, in working with people with mental health problems, cannot be overstated. Every contact is an opportunity to promote health (both physical and mental), and to take a recovery-oriented approach (p. 35)

It seems that neither service users, nor their families, are granted positions of expertise in their own mental health problems. Even in the above quotations, one notes that people are “given tools” and “supported in their own health” [presumably by experts]. Workers are encouraged to “work with” people with mental health problems in developing treatment. Thus we have the second class of identities that are produced, which is that of the Service Providers.

5.2.2.8.2 The Identities and Roles of Service Providers: The service provider as expert.

This category is less obvious but can be extrapolated from the discussions and analysis which has occurred. As described, the role of service users is mediated through the experts. These experts have been defined throughout

the document in general as workers (GPs, psychiatrists, workers, etc). The nature of the experts and expertise is discussed further below. Here I simply wish to highlight that the existence of the expert worker provides a "role" for the service provider as expert, who provides tools and knowledge to the service users, who "works with" service users for the betterment of the users' health. The role of service provider as expert is reinforced by the use of language and jargon as described in the general description of the document. The document itself as noted above is meant for the attention of the service provider as expert, rather than for the service user as recipient of expertise. This is reinforced through the use of jargon and meaning laden language.

5.3 Themes Within the Strategy

The final step of analysis of this document, was to capture discursive themes that recurred throughout the document. During the first few read-throughs, it became apparent that there were strong themes throughout the text that were not necessarily being captured by focusing on the questions of the analytic framework I was using. This step therefore constituted an attempt to capture these themes.

Themes were identified from three techniques: (1) an analysis of words, including word repetitions, and key-words-in contexts; 2) a careful reading of larger blocks of texts, in which phrases are compared and contrasted, and potential missing information is sought; and 3) an intentional analysis of linguistic features such as metaphors, transitions, connectors (Ryan & Bernard, 2003). Throughout, these themes were identified by careful reading and re-reading of the text. As potential themes were identified, further re-readings were used to verify whether or not they were significant or consequential.

The following list is inclusive of themes that appeared more than once, or with significant enough contextualization occurring within the text to conclude that the authors intended it to be of consequence.

- Evidence

- Expertise/Responsibility
- Human Rights
- Productivity/contribution to society
- Stigma and societal attitudes/vulnerability
- Criminality
- Risk

In the sections below, the themes will first be described and fleshed out individually, with reference to the literature where appropriate. Following this description, the themes will be situated within the macro-discourses of Rights-Autonomy and Harms-Paternalist, with a discussion following about how this affects the identities of people within these paradigms.

5.3.1 Evidence

Throughout the text, evidence emerged as a theme. Evidence was referenced in various ways, but throughout exclusively seemed to refer purely to positivist forms of knowledge. Samples of textual fragments include:

> *"… a Matrix of evidence-based interventions to improve the mental health and wellbeing of children and young people" (p. 4)*

> *"… Appropriate, evidence-based parenting programmes should be available…" (p.13)*

> *"… the rollout of evidence-based interventions that support children and their families through the Psychology of Parenting Programme." (p. 14)*

> *"… there is a need for a range of solid, evidence-based interventions for emotional, behavioural and/or conduct issues where a child would not be diagnosed with a mental*

illness but could be helped by a psychologically-informed approach". (p.14).

In these text fragments above, particularly in the latter two, one can see the linkages between "evidence-based interventions" and the field of "psychology". This direct link illuminates the idea that in this text, evidence-based is directly referring to the sorts of knowledge/evidence generated by fields such as psychology. This linkage is further reinforced in other textual fragments:

"Community triage, THRIVE and Distress Brief Interventions that are currently underway in this area in order to deliver improved, evidence-informed responses in the future" (p. 19).

This theme, as with many others, is relevant in not only what is present, but with regards to what is absent. A true recovery-oriented system should acknowledge the expertise and evidence that comes from lived experience (Swerdfarger, 2016). There would ideally be some expression of the value of this form of evidence embedded within as central a document as the Strategy. This does not occur. Instead, the references to evidence throughout this document are purely in reference to positivist evidence that comes from academic fields.

This point is reinforced here:

"If inequalities are to be tackled successfully, it will be important that local partnerships use good data about the makeup of their communities and ensure an appropriate targeting of actions to address issues for those most at risk." (p. 20)

The highlighting of the importance of "good data" is once again stressing the importance of rigorous data collection as evidence. This is in contrast to highlighting other forms of information that might be used to inform programs

mitigating inequality. The importance of data as a measure is reinforced later in the strategy, in a section which calls for the development of a "mental health strategy data framework". This section states:

> *"The Scottish government will develop a mental health strategy data framework. The aims are to have data that is [sic] useful to planners of services, clinicians, and people developing policy, and to cut back on the collection of data that is under-used or not fit for purpose…. Good data collection requires an underpinning of development and use of digital tools and better use of electronic information: as well as supporting data these can increase efficiency and improve healthcare outcomes in Scotland." (p. 37)*

The additional point to highlight with this quotation above is the emphasis on "efficiency" of services. It is also helpful to point out that again, here, with the emphasis on electronic information and digital tools, that data collection likely primarily refers to quantitative and epidemiological data such as statistics, demographics, prevalence and incidence, and so on. Such electronic databases are less useful for collection of qualitative data. This is not problematic in and of itself, except for the earlier reference to the removal of data collection that is "under-used or not fit for purpose". This phrase is offered in contrast to presumably "useful" data that is easily collected through electronic databases.

Another form the theme of "evidence" takes is through references to "best practice". A treatment technique is deemed "best practice" when it consistently demonstrates that it produces superior results (Dembowski, 2013). In health services, best practice is a nebulous term, but generally refers to processes in which the 'best way' to identify, collect, evaluate, disseminate, and implement information, as well as the 'best way' to monitor the outcomes of health care interventions (Perleth et al., 2001). It is important to note that in health care specifically, the term "best practice" encompasses the need for gathering of the best available evidence on the quality of

interventions. (Perleth et al., 2001). The importance of “evidence” is a fundamental component therefore of the concept of best practice.

> *“Best practice should be followed in the delivery of mental health treatment, with the evidence base and clinical guidelines as the basis for best practice: this is about the right treatment, with the right number of sessions, with outcomes monitored and recorded. Using evidence-based clinical guidelines to treat mental health problems will be important evidence that parity between mental and physical health is being achieved. Using them will also help to deliver on non-discrimination”. (p. 27).*

It is important to note that this quotation falls under the heading of “Parity of quality of treatment”. As with the above, in this context, the author(s) of the text clearly are linking “best practice” with “evidence”. This is reinforced by inclusion of reference to the collecting of quantitative data. The “right treatment” (which as we see in the next sentences means “clinical guidelines”) with the “right number of sessions” (implying a quantitative measure that is evidence based can be determined) with outcomes “monitored and recorded”. The monitoring and recording again is an appeal to positivist, rigorous data collection. Throughout this quotation, which is ostensibly about “parity of *quality* of treatment”, there is reference to quantitative measures, and continuous appeals to evidence and data. There seems to be the slightest implication then that the quality of mental health service simply falls to a question of proportionality first, and secondly to a question of a lack of proper use of “evidence”. Thus the implicit argument is that mental health services needs to be increasingly rigorous, and increasingly data-driven, in order to gain parity with physical health. This is a better fit with a medical model of mental health services, and certainly a business-model friendly vision of mental health services, than it is in line with person-centred and recovery-oriented care.

5.3.2 Expertise/Responsibility

A theme around “who is responsible” and “who holds expertise” in the health services emerged. That is, those who are empowered to enact policy or receive training to deliver mental health services are generally those who hold “expertise”, and are people who are specially targeted for receiving special training in mental health services. Such individuals are identified in the text in various spots:

> *“All adults who work in Scotland’s schools have a responsibility to support and develop the emotional, social and physical wellbeing of pupils… To support this responsibility, Education Scotland provides training and professional development, as well as promoting good practice on positive relationship and behaviour approaches” (p. 13)*

> *“… health visitors, midwives and school nurses – can play a role …” (p. 15).*

> *“Professionals working with children… ” (p. 16)*

> *“…staff in housing…” (p. 21)*

> *“Multi-disciplinary teams in primary care, to ensure every GP practice has staff who can support and treat patients with mental health issues”. (p. 23)*

> *“Access to services for mental health problems within a clinically appropriate timescale is a basic issue of health equality. There must be access to high quality, specialist mental health care for those who have higher levels of need, as well as general health care which can deal with an issue there and then for people with a mental health problem. (P. 23)*

> *"ACTION 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons" (p. 23).*

As one sees, there is an emphasis on the role of professionals, which certainly is to be expected in such a strategy. What is of particular interest here however is that the role of police is highlighted regularly (discussed in its own theme below), and the role of GP and primary care is also highlighted regularly. In general, there is more emphasis on professionals traditionally associated with medicalized mental health care, with lesser emphasis on community health service providers, and with only minimal reference to Third Sector providers.

It should be noted that this theme is closely related to the theme of evidence, in that it is the experts who hold the evidence that is necessary to develop good policy and best practice. There is an argument that in many ways, these two themes are subthemes of one another, but for the purpose of the thesis I chose to draw a distinction between the two for clarity.

5.3.3 Human Rights

Human rights are referenced throughout the document in many different contexts and are presented early on in the text as a primary theme of the text. That said, references to the rights of individuals tend to be stand-alone fragments with little follow up or context, and little to no detail expounding actual actions related to how to support these changes. At numerous points in the document, "rights-based approach" or similar language is generally quite hollow. An example is:

> *"Integration authorities and Local authorities will therefore wish to mainstream a recovery-oriented and rights-based approach throughout clinical services, through workforce development and use of tools like the IROC (Individual Recovery Outcomes Counter) and SRI2 (Scottish Recovery*

Indicator). The Scottish government will also consider how its support to the Third Sector can help to mainstream throughout health and social care services a recovery-oriented and rights-based approach" (p. 35).

Despite numerous references to human-rights based care no specific human rights are cited in the entirety of the document, nor are specific references made to any human rights treaty or convention in the text of the document. This is despite, as discussed in Chapter 2, a robust background of literature supporting specific recommendations in how rights should be protected.

Within the text of the document, however, actual commitment to the human rights of people in Scotland with mental health problems, is generally relegated to vague, nonspecific generalities such as:

"our efforts must deliver on a human rights-based approach, so that people in the most marginalized of situations are prioritized in achieving health". (p.3)

Examining this quote, one sees that a human-rights based approach remains largely undefined. It receives no specifiers here or elsewhere, and it similarly is with minimal reference to external documents or frameworks that might inform policy makers which rights and how to implement a rights-based approach, with only one exception:

There should be a human rights-based approach to the improvements needed, using the PANEL principles of Participation, Accountability, Non-discrimination, Empowerment and Legality.

This is the only external guidance offered on how a rights-based approach might be implemented. PANEL principles are endorsed by the Scottish Human Rights Commission (2022) as a way to put human rights guiding principles into practice. These guiding principles are also consistent with recommendations by the World Health Organization in ensuring human rights are meaningfully present in policy development (2017), and that people

affected by policy are actively engaged in policy development. They are not further explicated here.

In this following quotation, the commitment to Rights is ambiguous and takes on confusing meanings (p.6):

> *Rights, information use, and planning:*
>
> *32. Use a rights-based approach in the statutory guidance on the use of mental health legislation.*
>
> *33. Commission a review of whether the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 Act fulfil the needs of people with learning disability and autism, taking forward new legislative measures if necessary.*
>
> *34. Reform Adults With Incapacity (AWI) legislation.*
>
> *35. Work with key stakeholders to better understand Mental Health Officer capacity and demand, and to consider how pressures might be alleviated.*
>
> *36. Work with employers on how they can act to protect and improve mental health, and support employees experiencing poor mental health.*
>
> *37. Explore innovative ways of connecting mental health, disability, and employment support in Scotland (p.6)*

These points are taken from the Summary of Actions. What is notable is how many of these points simply refer to non-rights-based legislation. The Mental Health and Adults with Incapacity Acts are important, but are not centred on rights per se, and are certainly not specifically about patient rights.

The match between rights here, with the other elements of the subheading, is unclear. It gives the overall impression that “Rights” in the context of this quotation, is used synonymously with “laws”. Certainly, an uninformed reader

would easily conflate rights with laws in this context, coming under the heading as it does of “Rights, information use, and planning” (p. 33).

Then, when one reads further into the strategy to where this action point is addressed in further detail, one sees that the ambiguity between human rights and mental health legislation remains:

> *A human rights-based approach is intrinsic to actions in this Strategy. This is being addressed through the PANEL principles: Participation, Accountability, Non-discrimination and equality, Empowerment, and Legality.*
>
> *Our mental health and incapacity law sets out principles which have been at the forefront of a rights-based approach to law in this area. International law continues to develop and other jurisdictions have taken the step to overhaul their mental health and incapacity legislation. The approach taken here is to take account of supranational observations, build on existing good practice, and learn from other jurisdictions and about what works well. (p. 33)*

The emphasized section is in essence a deferral of action rather than an action. Thus, despite centralizing a “rights-based approach”, it would seem that there are no immediate plans for a radical reconstruction of legislation to be more in line with human rights.

Further, the strategy goes on to state:

> *The implementation of mental health law will promote the realisation of the human rights of people experiencing mental health problems. This will also be a focus of a co-ordinated approach to any review of incapacity legislation and its interaction with mental health law. We will continue to work with partners on support for decision- making. (p. 33)*

The statement "*The implementation of mental health law will promote the realisation of the human rights of people experiencing mental health problems."* is striking. The associated action items are:

> *Action 32: Use a rights-based approach in the statutory guidance on the use of mental health legislation.*
>
> *Action 33: Commission a review of whether the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 Act fulfil the needs of people with learning disabilities and autism, taking forward new legislative measures if necessary. (p. 33)*

Action 32 is laudable, and a step in the right direction towards implementation of human rights-based approach. While it makes no suggestion of radical reformation of the mental health act or associated legislation, it does commit to taking some action toward at least addressing the *application* of legislation. As noted previously, the individuals who use laws and policies are the mediators of them. This indicates flexibility and allowance of latitude in the application of the existing law, even as it falls short of suggesting actual changes.

Action 33 commits to a review of legislation that applies to individuals who are disabled. This, as discussed in Chapter 2, does not apply to all persons with mental illness or mental disorders. It would seem to be aligned with the need to address the CRPD, a conclusion reinforced by the next quotation addressed below.

In the following quotation we see the single in-text reference to human rights legislation, which is the CRPD. This is an interesting exception, given the ambiguity between which adults with mental illness fit within the CRPD (as discussed in Chapter 2).

> *Adults with Incapacity Legislation (AWI)*

> *Adults with Incapacity legislation should fully reflect the requirements of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), with particular emphasis on provision of supported decision making, addressing issues around deprivation of liberty and the interaction of AWI legislation with the legislation on mental health and adult support and protection.*
>
> *Action 34: Reform Adults With Incapacity (AWI) legislation (p. 34)*

The CRPD then is privileged in the Strategy, over and above other forms of human rights legislation. Again, this may benefit many people with mental health problems, but not necessarily all. Still, it is certainly a promising step, and is the strongest and most specific commitment towards rights-based legislation in the Strategy. The associated Action 34 is a step away from the previous language around legislation, in that it directly commits to reformation of legislation.

The privilege the CRPD enjoys might be because it is the most recent human rights treaty affecting this population, and there are likely political pressures that were directly influencing the authors of the Strategy at the time of writing, to ensure that the CRPD is represented in the document.

Other references to rights are embedded in addressing resources that are needed to support the rights of people with mental illness:

> *The independent role played by social work Mental Health Officers (MHOs) is central to ensuring that people's human rights are protected and upheld when their care and treatment involves compulsion or can include detention. (p. 34)*

This thus seems a truer representation of rights as embedded in the Rights-Autonomy Discourse, than previous examples of how “rights” are described in the Strategy.

The Strategy has an interesting reference that bears some scrutiny:

> *The implementation of mental health law will promote the realization of the human rights of people experiencing mental health problems.*
>
> *This will also be a focus of a co-ordinated approach to any review of incapacity legislation and its interaction with mental health law. We will continue to work with partners on support for decision-making. (p. 33)*

The associated actions are:

> *Action 32: Use a rights-based approach in the statutory guidance on the use of mental health legislation.*
>
> *Action 33: Commission a review of whether the provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 Act fulfil the needs of people with learning disabilities and autism, taking forward new legislative measures if necessary. (p. 33)*

The goal of applying mental health law in a way that is rights-promoting is not further explicated. The first action states that rights-based approaches will guide implementation of the existing laws and that new “legislative measures” should be taken forth “if necessary” – presumably “if necessary” entails if the existing law is not able to meet the rights of people.

5.3.4 Productivity/contribution to society

In the literature, engagement with employment is shown to have a positive correlation with mental wellbeing (Grey et al., 2019). There is evidence that employment status, and employability, can impact one’s position in society,

and this is also demonstrated to be true of people with mental illness (Fleming et al., 2019). This perception – that employability and social status are positively linked - is reflected within the Strategy. For example:

> *Employment: Not having a job is the single biggest inequality that people with mental health problems can face. We will use our new employability powers to work across health and employability services to support people with mental health problems to stay in work and to support people to get back into work. We will also encourage employers to support the mental wellbeing of their employees. (p. 8)*

> *Getting a job and staying in work*
> *Work can be good for mental health. Not being in work can be a factor in poverty, which is a determinant of mental ill-health. People with poor mental health are less likely than people with poor physical health and people with good health to transition from unemployment to employment (p. 34)*

> *Labour market policies should focus on assisting people with poor mental health to move from unemployment into employment, and public health and employment initiatives must focus on assisting people to stay in work. (p. 34)*

This repeated reference to employment is notable in relation to both the Rights-Autonomy and the Harms-Paternalist discourses. In the first case, and as is explicitly reflected in the Strategy, we see that employment is positively linked to good mental health. However, in the case of the Harms-Paternalist discourse (and as we see in the literature review), there is a notion that people with mental health problems are seen to be less valuable to society due to their employability status. This perception might be reinforced by the repeated explicit inclusion in the Strategy.

5.3.5 Stigma

Stigma is acknowledged within the Strategy as an obstacle to wellbeing. It is interesting that stigma is addressed in two ways: First, as an issue faced by people with mental health problems – an inherent trait of living with mental health problems; and second, as something that can contribute to the challenges of mental health problems.

Regarding the first aspect of stigma, examples include …

> *We want to create a Scotland where all stigma and discrimination related to mental health is challenged, and our collective understanding of how to prevent and treat mental health problems is increased (p.2)*

> *Students of further and higher education face some unique challenges, but we want to ensure a consistent level of support for mental health across the country. These education settings also provide opportunities to help address stigma and discrimination, and support efforts towards self-management (p. 18)*

This first way of thinking about stigma and mental health problems acknowledges the discursively created reality of the label of mental health problems. Stigma is well known to affect the daily lives of people with mental health problems and the Strategy acknowledges it as a primary source of difficulties.

The second aspect of stigma is as something that can further contribute to the challenges of mental health problems that otherwise exist. This adds a layer to the understanding of stigma within the Strategy: That there is a primary, direct stigma that impacts opportunity externally from others, and that there is a secondary level of difficulty related to marginalization. That is, that stigma can create direct problems from without the individual (difficulties finding employment, barriers to seeking care resulting from discrimination) as well as indirect ones (such as not seeking employment or care in the first

place, as one is expecting to experience stigma or rejection). This second aspect is seen in the below quote:

> *Where people do not feel welcomed, or do not see themselves represented, it can be hard for them to open up about mental health problems or to believe they will be listened to. Differences in ethnicity, sexuality, or gender identity, for example, should not be barriers to receiving high quality services to treat mental health problems. (p. 21)*

Though not as explicitly, stigma, or societal attitudes towards people with mental health problems, also arises in discussions around risk and vulnerability:

> *Some groups are more likely than others in our society to experience mental ill-health and poorer mental wellbeing – for example, people who have experienced trauma or adverse childhood events, people who have substance use problems, people who are experiencing homelessness, people who are experiencing loneliness or social isolation, veterans, refugees and asylum seekers. (p. 11)*

These discussions in the Strategy reinforce the perceptions of stigma as pervasive and multi-faceted. These perceptions are well supported by the literature, and it is notable that the subtlety of stigma seems to be captured within this document. This is a positive sign that some messages within the Rights-Autonomy discourse are making headway into the archive.

5.3.6 Criminality

Throughout the strategy are references to the relationship between people with mental health problems and the criminal justice system. The criminal justice system is regularly referenced as a key partner in delivering mental health services.

In fact, they are named in one point, under the goal of "access to treatment and joined-up accessible services, alongside primary health care services, thusly:

> *"Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons" (p. 4)*

This point is the first point under the summary of actions that will facilitate the access to treatment goal. This creates an early impression that police custody and prisons are a primary target of increasing access alongside primary care facilities.

The frequent references to the justice system and to Police Scotland emphasizes the close links between the mental health system and the justice system. Further, the repeated references to these links in this Strategy creates the impression that these links are expected to continue without significant change. This creates a general impression (which overlaps with the next theme of Risk) that there is a natural link between the two systems.

> *"Support an increase in support for the mental health needs of young offenders…" (p. 4)*

> *"Support efforts through a refreshed Justice Strategy to help improve mental health outcomes for those in the justice system" (p. 4)*

> *"Working across the wider public services to harness the broadest range of opportunities to improve the population's mental health… for example… Justice: We will support the justice system to work effectively with local partners to improve outcomes for people with mental health problems. We will facilitate work with Police Scotland and Integration Authorities to ensure that people with mental health problems or who are in distress are supported."*

Mental Health and the Justice System receives its own dedicated section within the strategy. The mental health strategy makes numerous references to the Justice strategy and to the Police Scotland strategy (which is discussed in Chapter 4).

As discussed above regarding the "formation of identities" within the Strategy, references to criminality are relevant to the perception of people with mental health problems as dangerous. Some examples are offered below of how the theme of "criminality" produces an overall impression of a strong relationship between crime and people with mental health problems; and how the Strategy offers a solution to issues related to mental health services in the form of increased funding and resourcing specifically to Policing.

> *This Strategy does not just focus on traditional mental health services. In comparison to the general population, the prevalence of mental health problems among those in contact with the justice system is high.(p. 18)*

In this instance, it is notable that the quotation is in reference to criminal involvement of youth: It seems that a problem is defined here such that youth are more often involved in the criminal justice system, and the solution is defined through Police Scotland.

> *Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.*

In this case the problem is that mental health systems and services are underfunded and under resourced. Here, the solution is directly linked to increased resourcing dedicated to "police station custody suite[s], and…

prisons". It is notable that the Strategy does not explicitly state that this increased resourcing is to divert people appropriately from custody or prison to mental health services.

5.3.7 Risk

As a theme here, "risk" is somewhat closely related to criminality, and is one of the themes present throughout the archive. As throughout Chapter 4, risk is inherently associated with life with mental health problems. The risks that are identified in this document tend to be risks of harm, to self or others:

> *Determine and implement the additional support needed for practitioners assessing and managing complex needs among children who present a high risk to themselves or others (p. 4)*

As well as risk of engaging in behaviours that are "undesirable", such as substance use.

> *the prevalence of mental health problems among those in contact with the justice system is high. Mental health issues commonly co-exist with problem substance use (alcohol and drugs), chronic physical health conditions, learning difficulties, and homelessness (p. 18)*

The theme of risk could potentially be seen to exist within both major discourses. However, in the Strategy, as seen in the above quotes, it is discussed largely in terms of the behaviours of people with mental health problems creating risk for themselves or others.

5.3.8 Economic Factors

Economic factors are named often throughout the document. While this may strike one as unsurprising, as governments are centrally concerned with costs and budgeting, the phrasing used and emphases placed on economic factors is at times instructive:

We want a Scotland where we act on the knowledge that failing to recognise, prioritise and treat mental health problems costs not only our economy, but harms individuals and communities. (p. 2)

Good data collection requires an underpinning of development and use of digital tools and better use of electronic information: as well as supporting data these can increase efficiency and improve healthcare outcomes in Scotland. That is, of course, a cross-cutting agenda. (p. 37)

"Of course", increased efficiency is a cross-cutting agenda.

Develop a quality indicator profile in mental health which will include measures across six quality dimensions – person-centred, safe, effective, efficient, equitable and timely (p. 37)

Health and financial benefits come from reduced lengths of stay, reduced re-admissions and investigations and improved care of medically unexplained symptoms, dementia and long term conditions. (p.30)

Stopping smoking can reduce depression, anxiety and stress and can reduce the long term risk of cancer – all of which can have a positive impact on the individual and a reduction in healthcare costs . (p. 31)

Thematically this factor is not as strongly related to either of the major discourses except on the most superficial of levels. However, the prevalence of concern for economic factors is notable in that it will shape future policy agendas. The priority given to economic efficiency can cause issues with making major changes in policy moving forward.

5.3.8.1 Recovery and "Sustainable" Services.

It was discussed earlier how "recovery-oriented" services are assumed within the text. There is one passage that is striking and deserves scrutiny for how it

reveals some underlying assumptions and beliefs about recovery-oriented services. It is in this passage that "recovery-oriented services" are most directly referenced. The following is taken from Page 35, under the section titled "Support people to manage their own mental health". The emphasis in the quotes text below is mine:

> *Evidence indicates that where people have the tools to manage their own health – including being supported to do so, such as through social prescribing - then their wellbeing may be improved….*
>
> ***The Scottish Government's ambition is for a sustainable health and social care system*** *which helps to build resilient communities.* ***There needs to be a strategic shift towards recovery models focused on assets, strengths and self-management.*** *This is fundamental not only to how mental health services are designed and provided, but fundamental to the design and provision of all services that have the potential to improve mental health and wellbeing. This goes substantially beyond the scope of health services….*
>
> *Integration Authorities and Local Authorities will* ***therefore wish to mainstream a recovery-oriented and rights-based approach throughout clinical services*** *… The Scottish Government will also consider how its support to the Third Sector can help to mainstream throughout health and social care services a recovery-oriented and rights-based approach.*

This passage indicates an underlying belief that recovery-oriented services can help relieve burdens on mental health services (making services more "sustainable"). The direct linkage between this passage – containing the most direct and detailed references to recovery-oriented service – and sustainability of health and social care systems, has the effect of stating that

the primary value recovery-oriented services has within the Strategy is due to this intended effect. That is, the reason recovery-orientation is important or valued within this text is due to the potential for individuals to “manage their own health” and thus allow services to be more “sustainable” – presumably because people managing their own health results in less need for them to access formal services.

5.4 Discourses in the Strategy

As per the plan of analysis outlined at the start of this Chapter, this document was first analysed as a stand-alone document (as above), then re-examined with an eye to the intertextual discourses identified in the documentary archive. The Strategy was read (and re-read) to assess the different ways in which it reinforced and promoted the Rights-Autonomy discourse and the Harms-Paternalist discourse. In this section I discuss how the different themes that were identified in the Strategy map onto the Rights-Harms Model developed in Chapter 4.

5.4.1 The Strategy in the Textual Archive

The same figure from Chapter 4 [figure 4.1] is presented here as a reminder of how the Strategy relates to other documents within the textual archive:

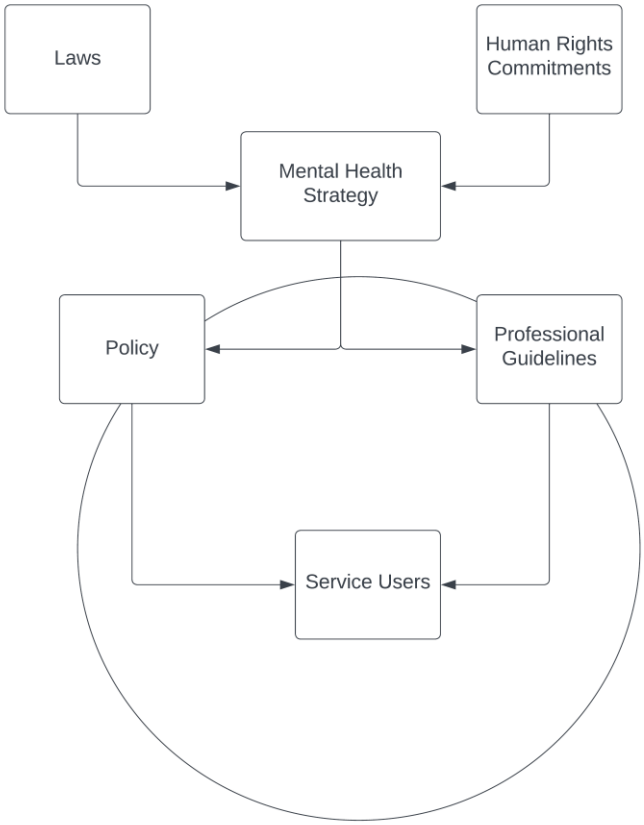


Figure 4.1 **Relationship between the Documents**

The textual archive (containing human rights documents; laws; policies/procedures, etc) “feeds” discourses into the mental health strategy which in turn, presumably, will recontribute those discourses back into the archive over time. That is, the discourses that exist in the documentary archive are present within the mental health strategy and remain relatively (if at all) unchanged by the Strategy. As such, there is no expectation that these discourses in the archive will appreciably change due to the Strategy. There is no incentive provided to increase the presence of the Rights-Autonomy discourses at the cost of a reduction in the Harms discourses.

As discussed in Chapter 4, those documents that represent ‘grassroots’ movements are those that seem to best represent the discourses related to Rights and Autonomy. At this point there are few reasons to believe that the Mental Health Strategy is appreciably influenced by these texts produced at the grassroots, and there is an argument to be made (as will be done in

Chapter 6) that the next strategy needs to attend much more to these documents in a bottom-up approach.

In Table 5.5, below, I offer an assessment of how the various themes identify above fit within and reinforce the two macro discourses (i.e. intertextual discourses) identified in the archive. I take each theme identified and provide a brief summary of how it reinforces each of the two macro discourses (or if it fails to). In the fourth column, themes and identities that were identified in Chapter 4 are also identified. This is intended to demonstrate the ways in which the Strategy fails to capture identities/roles/problems, and so on, that are represented in the archive. Further discussion is offered below the table.

Table 5.5 Macro Discourses in the Strategy

Theme	**Discourse**	**Actual Identities/Roles/ Problems Produced in Strategy**	**Other potential Identities/Roles/Problems, as produced in other documents in the archive**
Evidence	Harms-Paternalist	Evidence comes from experts and is given to service users Good data, in the form of expert data, is the source of good policy and best practice	Service users provide unreliable data
	Rights-Autonomy	There seem to be no identities formally produced by the Strategy that relate to “evidence” within a Rights-Autonomy framework	Evidence comes from lived experience Best practice can be fluid and person-centred
Expertise	Harms-Paternalist	Service Provider as Expert	

	Rights-Autonomy	Service providers can work with people to produce good health outcomes	Service User As Expert Mental health services should be radically redesigned to centre the service user, their treatment choices and preferences.
Human Rights	Harms-Paternalist	Human rights are given through laws and incorporated into existing frameworks Adults with Incapacitation Act facilitates rights	Human rights may be suspended due to risk to self or others
	Rights-Autonomy	Human rights-based approach is needed, but undefined CRPD defines the parameters of human rights going forward	Human rights are central to the provision of good mental health services; human rights are non-negotiable elements of care*.
Productivity	Harms-Paternalist	Non-participation in employment is both a risk factor for mental health problems and is a measure of wellbeing and improvement	People with mental health problems do not contribute to society by definition (are unable to function in work/education).
	Rights-Autonomy	People with mental health problems should be given full access and support to engage in employment	Productivity is not the measure of the value of a person to society

Stigma	Harms-Paternalist	Stigma is an inherent trait of living with mental illness	
	Rights-Autonomy	Stigma is damaging to the wellbeing of people with mental health problems	
Criminality	Harms-Paternalist	People with mental health problems are more likely to be engaged with criminal and anti-social behaviours	
	Rights-Autonomy	There are no notable identities/roles/problems identified here. Notably absent are references to people with mental health problems as victims of or vulnerable to crime	People with mental health problems are more likely to be victims of crime
Risk	Harms-Paternalist	People with mental health problems are vulnerable People with mental health problems are likely to be involved in risky behaviours	
	Rights-Autonomy	Inequalities produce risk	

5.4.2 The Rights-Autonomy Discourse

The commitment to the Rights-Autonomy discourse themes are not only lesser in number, but they are notably lesser in intensity. That is, they are

resourced to lesser degrees and are described in less detail. References to the rights of people with mental health problems are vague.

Evidence: There are no discernable references in the Strategy to the fact that service users as providers of evidence. All references to evidence are consistent with the Harms-Paternalist discourse (see below). There is a missed opportunity here to provide a framework for receiving information or data from service users, in a manner that contributes to their own care.

Expertise/Responsibility: While there are some general references to the right of people to determine their own treatment, this is only done in direct reference to it happening with the expert guidance of a service provider. As with “evidence” this represents a missed opportunity to respect the knowledge of individuals in their own experiences as “expertise”, which would be consistent with recovery-oriented care (Anthony & Ashcraft, 2010). It most certainly does not engage with any notions of recovery-oriented or person-centered reformation that are present in the literature and in Rights-Autonomy discourses in the archive, which state that mental health services should be redesigned to center the service user, their treatment choices and preferences.

Human Rights: The Strategy fails to engage in a substantive way with the issue of Human Rights. Per the Strategy, a human rights-based approach is needed, but is completely undefined. In the only way it is substantiated, it references the CRPD as defining the parameters of human rights based care going forward. However, this fails to consider the issues (as discussed in Chapter 2) that the CRPD can be ambiguous regarding how all persons with mental health problems fit within the framework of the Charter.

Productivity/contribution to society: The Strategy engaged with the question of productivity exclusively through language of employment: That people with mental health problems should be given full access and support to engage in employment. While it repeatedly references the value of employment to wellbeing, it fails to engage any nuances to the question of

employment for people with mental health problems. However, on a more positive note, the Strategy also does not engage with Harms-Paternalist oriented notions that people with mental health problems are not able or willing to participate fully in employment.

Stigma and societal attitudes/vulnerability: The Strategy acknowledges that stigma is damaging to the wellbeing of people with mental health problems, but again misses an opportunity to engage with nuances of how it contributes to vulnerability (or indeed, how it contributes to service delivery, employment, or other issues deemed central within the Strategy).

Criminality: The Strategy fails to engage with the vulnerability of people with mental health problems to crime.

Risk: The sole manner in which the Strategy engages with questions of risk from a Rights-Autonomy perspective is to state that risk is produced by inequalities, and as such inequalities should be addressed.

5.4.3 The Harms-Paternalist Discourse

In contrast with the Rights-Autonomy macro-discourse, the Strategy produces stronger identities, roles and defines numerous problems that are consistent with the Harms-Paternalist discourse.

Evidence: All references to evidence are consistent with the Harms-Paternalist discourse. In the strategy, evidence (in the form of ‘best practice’, etc.) comes from experts and is given to service users from there. ‘Good’ data, that is to say, expertly produced data, is presented as the source of good policy and best practice. As noted in Table 5.5, this may reinforce notions found within the archive that service users (lived experience) produced unreliable and non-transferable knowledge.

Expertise/Responsibility: The Strategy produces a concept of service provider as expert. These service providers can be any professional who is working in mental health services, and especially includes physicians

(including general practitioners), nurses, social workers, mental health officers, educators and police.

Human Rights: Human rights are given through laws and incorporated into existing frameworks in the Strategy. The Strategy does not engage with or mention the fact that human rights can be limited or constrained. While this latter point can be seen as a positive, it fails to acknowledge the reality of the situation that such rights can in fact be suspended. This could represent a missed opportunity to provide strong statements that such suspensions of rights should be approached with extreme caution and should be limited by all means possible.

It is interesting to note that the Strategy specifically notes that the Adults with Incapacitation Act facilitates (rather than limits) the rights of service users. Again, this represents an interesting choice in language and perspective. The Adults with Incapacitation Act can be seen to be protective of people from abuse, but it can do so via the removal of the rights of people to make free choices. As such, the framing of this specific Act as “facilitative” of rights (without mention of other uses of the Act) communicates a perspective that is consistent with the Harms-Paternalist discourse, in that it is highly paternalistic view of rights: That the protection of rights entails others to intervene on the behalf of people who are unable to act on their own.

Productivity/contribution to society: The Strategy references employment numerous times. It holds that non-participation in employment is both a risk factor for mental health problems and is a measure of wellbeing and improvement. As noted above it fails to engage with nuances of the question of employment, and simply identities employment of people with mental health problems as a priority for interventions.

Stigma and societal attitudes/vulnerability: References to stigma within the Strategy imply that it is an inherent trait of living with mental health problems. The Strategy does not engage in a substantial way with questions

of how societal influences and attitudes are generated and may be altered. It simply acknowledges the existence of stigma and that it creates issues.

Criminality: People with mental health problems are more likely to be engaged with criminal and anti-social behaviours. The repeated associations between mental health services and the criminal system are noted in detail above, and thus won't be repeated here. At this point, I simply note that this theme is repeated, strong and strongly associated with the Harms-Paternalist principle that people with mental health problems are more likely to commit crimes and be of a danger to themselves or others.

Risk: The Strategy states that people with mental health problems are likely to be involved in risky behaviours, are more likely to be a harm to themselves or to others. It fails to engage with nuances of these risks, such as how it is related to the issue of stigma.

5.5 The Strategy and Its Goals: Internally Inconsistent

In this section, I will address a central question of the Strategy as it relates to mental health services in general. I argue when you examine the discourses that are present and the tensions that exist between them (as discussed above), that it contains internal inconsistencies, such that it fails to actually achieve the goals that are stated within the text.

The purpose of the strategy, as is noted within the strategy introduction, written by MSP Maureen Watt, Minister for Mental Health, is ostensibly to

> *"…prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems". (p. 2)*

This statement draws a parallel between mental health and physical health. The aim could be to de-mystify mental health and to make the case that mental health should have access to proportionate levels of funding and service as goes to physical health. There is no apparent reason to read any other intentions into this statement in the Strategy.

It should be noted, as an aside (as this is beyond the scope of this project), that there is little to suggest in the body of evidence that mental health and physical health share much in common biologically or ontologically. This parallel thus is an effective marketing strategy deployed to influence the perceptions of the general public. However, one wonders if there may be a future downside to using a factually flawed assertion in this way.

It goes on to state

> *"We want to create a Scotland where all stigma and discrimination related to mental health is challenged, and our collective understanding of how to prevent and treat mental health problems is increased." (p. 2)*

It is notable in this section that the Strategy explicitly mentions stigma and discrimination. This statement further implies a collective, or communal, responsibility regarding mental health/illness. This draws in broader society as a target for intervention. From the perspective of the research question, this is an invitation to the general public to engagement with the issue of discrimination. This incorporates themes related to the Rights discourse and encourages individuals to think of how to lift up individuals with mental health problems.

Further:

> *"We want to see a nation where mental healthcare is person-centred and recognizes the life-changing benefits of fast, effective treatment. We want a Scotland where we act on the knowledge that failing to recognise, prioritise and treat mental health problems costs not only our economy, but harms individuals and communities. In short, we share the ambition that you should only have to ask once to get help fast" (p. 2)*

This statement stands out for its prioritization of the economy, listed before the harm to individuals and communities. This contains aspects of the Harm discourse, wherein mental ill health is a burden, creates a drag on the economy and thus on society. It is an odd fit with the following sentence. This creates the message that truly, the intent to create a system where one only has to "ask once to get help fast" is directly connected to mitigation of the harm created by mental ill health; primarily the harm to the economy.

And:

> *"In the last decade mental health services have changed dramatically… but we have ambition to go further…. Throughout this strategy we set out 40 initial actions to better join up our services, to refocus these and to deliver them when they are needed." (pp. 2-3)*

This quote is notable as it lays out the objectives of the Strategy as "better joining up services" and "refocus[ing]" them. This is quite different from either scaling up, or realigning them. This is despite the use of the phrase "sea change" (p. 3), which follows.

> *"Our efforts must deliver on a human rights-based approach, so that people in the most marginalized of situations are prioritised in achieving health"*

This statement alludes to the fact that persons with mental ill health are the "most marginalized", and states that such groups must be prioritized, which is in alignment with the rights based approach to health, and to the Rights discourses noted in the archive. It is also the first explicit mention of the rights-based approach to mental health. Notably, in a theme that is echoed throughout, this is not explicated, expanded upon, or contextualized.

> *"We can't achieve a sea change in mental health alone. The strategy also underpins how we will work in partnership with others to champion the better Scotland our people deserve".*

This is the concluding statement of the introduction. As previously noted, it references a “sea change” without committing to such in the more detailed list of commitments (which is restricted mostly to redistribution and refocusing of existing resources).

The Strategy, above all else, is an intentional document. It was created with intent and reflects intent. It was drafted, and went through rounds of consultations [Scottish Government, 2016], before it was published. It is absolutely justifiable then that we assume that the wording of the Strategy is carefully constructed to convey messages as well as to delineate actions, to direct the next 10 years of policy and practice in mental health services.

First, as in the above analysis, it seems that the strategy is committed to maintaining the status of GPs and other experts: especially GPs. If anything, this strategy increases the powers of GPs – even those without specialized training. Though, it does commit to increasing the training of GPs in mental health. This reinforces not only the medicalization of mental illness, but the centrality of medical practitioners in its treatment. This increases the separation of community-based treatment from the centre of treatment. It remains committed to service providers as expert, rather than service users as expert.

The commitment to scaling up currently existing services, rather than re-orienting them entirely, maintains the stated commitment that mental health is of a like with physical health, and thus under the remit of medical practice.

This leads to a conclusion that while its stated purpose is in many ways oriented towards rights-based and community-based care, it continues the entrenched reality that mental health services are medical, and should be focused on preventing harm. Thus, it is not fit for its stated purpose. However, if one reads the subtext of the harm discourses embedded within the text, one realizes it remains fit for purpose if one holds the harm discourses as the true purpose of the Strategy.

5.6 Conclusions and Key Points

Chapter 5 was dedicated to addressing Research Question 4: Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation? To this end, Scotland's current mental health strategy was examined. The analysis provided insights into both Research Question 4, as intended, but also provided some further insight into Research Question 1 (How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental health problems? How are mental health service providers represented in this relationship?) Specifically, the insights gained from this analysis helped to address RQ2: How are mental health service providers represented in the relationship between society and people with mental health problems?

The conclusion reached from this analysis was that the Strategy remains committed to discourses related to the dangerousness and harm of people with mental health problems, and their valuation as economically non-contributing members of the work or study force. It thus remains embedded in historical themes – as were discussed in Chapter 2 - of people with mental health problems as potentially dangerous, stigmatized, and requiring treatment from experts. While at the same time, it provides little actionable guidance towards supporting people in their own treatment goals, in mitigating inequalities at the root of the identified risks to people with mental health problems, or indeed towards realizing the human rights of service users.

Much of the defined support in the plan in fact involves simply increasing aspects of the current medicalized system. (e.g. increasing access to GPs), thus tacitly reinforcing the effects of the Harms-Paternalist Discourse, along with reinforcing the role of mental health service providers as embedded within a medical system. As discussed in the literature review (Chapter 2), the emphasis on medicalization further disempowers service users as decision makers in their own care, emphasizing the legitimacy of medical

practitioners in understanding mental ill health and prescribing treatment for it. I argue here that this impedes full access to the rights of people with mental health problems. On the other hand, commitments to the Rights-Autonomy discourses remain to weak and under-resourced to counter this effect.

There are numerous issues in the Strategy identified in this Chapter. Explicitly, the Strategy aims to address the inequity of health care services: Namely, it is meant to address the issue that mental health services are less valued and less resourced than physical health services. The Strategy explicitly identifies insufficient human resources; lack of preventative and less intensive services; insufficient school counselling; a need for mental health in primary care; and the need for increased engagement with mental health stakeholders.

The Strategy additionally states that services must “deliver on a human-rights based approach” (p.1), implying, of course, that human rights is not currently at the centre of mental health services.

This Chapter argues that the presuppositions underlying these identified problems are that the current system and general layout of the system is appropriate – it is simply a distribution of resources that is at issue. That is, proportionately we can change resource distribution, and achieve an appropriate form of services for people with mental health problems. This assumes that in many ways, the current system is the correct one: There are no radical reformations that are required to achieve the outcomes that are needed. Indeed, to achieve the human-rights based approach, one only need to re-emphasize certain forms of service that already exist.

One might conclude that numerous historical forces, as were discussed in Chapter 2, collided to lead to this representation of the problem. One might assert that the medicalization of mental health problems is particularly important in understanding this representation of the issue. In this representation, the “system” itself is left unproblematic. It is depicted as an

appropriate way of delivering care, but disproportionate. The “solutions” proposed are simple re-distributions of current resources. The current “evidence-base” is left unproblematic and remains unchallenged. There are no alternate forms of “evidence” that are proposed, despite appeals to engagement of stakeholders.

This representation is the prevailing one in Scotland and throughout the West, as discussed in Chapter 2. It is dominant in policy documents and throughout the archive. It is certainly consistent with the documents in the archive that represent official, governmental organizations. The Strategy makes mention of human rights and the need to acknowledge them, and this would be consistent with the messages from activism. But as noted, the Strategy does not go past mentioning human rights and thus does not in fact contribute to these discourses in any meaningful way.

The discourses that exist in the documentary archive are present within the mental health strategy and remain relatively (if at all) unchanged by the Strategy. As such, there is no expectation that these discourses in the archive will appreciably change due to the Strategy. There is no incentive provided to increase the presence of the Rights-Autonomy discourses at the cost of a reduction in the Harms discourses. Thus a reciprocal relationship is established between the archive and the Strategy, and it is expected that the Strategy will not be able to make appreciable difference in altering or mediating the presence of the tensions that exist in the archive. Under these circumstances it seems real change towards rights-based care is unlikely.

Chapter 6 Discussion

The critical analysis of documentation related to mental health services in Scotland revealed two major discourses that dominate policies and practice guidelines that shape mental health practice in Scotland. These two discourses exist and are reproduced in interactions between society (including service providers) and service users: They reciprocate and resonate between mental health services and broader society, and are thus amplified, reinforced, and entrenched, as described in the previous two chapters. The two discourses also act in opposition to one another between and within the texts, as seen in the Mental Health Strategy. Within the mental health strategy, the Harms-Paternalist Discourse is strongly present, even though the text itself describes an ambitious commitment to Rights-Autonomy principles. Between these macro-discourses are discursively constructed identities inhabited by people with mental health problems in relation to the use of services and supports from mental health service providers. These identities are summarized as people who are vulnerable but not vulnerable enough for protections, and autonomous, but dangerous.

This creates the effect of a widening gap between the opposing principles upon which mental health services are based. The strength and pervasiveness of Harms-Paternalist Discourses prevent progress in designing and implementing rights-based, person-centred mental health services. For example, it is difficult to develop a person-centred service model when expertise is fully ascribed to experts, not to service users. It is difficult to develop a right-based model of service when human rights are conceived solely as a product of certain laws that focus on competence or disability. Thus, one might conclude that under the current Strategic directions, the gap between the two discursive forces in mental health services in Scotland will remain unaffected and services will be drawn into the status quo.

While the analysis to this point has focused on the textual archive, this Chapter will provide some discussion of the implications of these tensions

(the socio-diagnostic critique) and will provide an analysis of potential actions that might disrupt this tension in the future (prospective critique). This Chapter will utilize understandings drawn from the literature review (Chapter 2) to inform the analysis of likely effects of the status quo and possible remedying actions. This Chapter will consider the implications of the evidence and take an argumentative and critical stance towards mental health services in Scotland in a broad sense. Note that the following Chapter will further utilize these to address the question of noncriminal exploitation more specifically. Chapters 6 and 7 should be taken as attempts at furthering the discussion into broader areas of concern arose, and identification of areas of further research and study. Further, Chapters 6 and 7 are intended to provide further analysis of the data with the aim of answering Research Question 3: What are the obligations – moral or otherwise - of mental service providers in addressing noncriminal exploitation of people with mental health problems?

6.1 The Socio-Diagnostic Critique

Discourse Historical Approaches [DHA] can be utilized in order to conduct an informed analysis of the discourses from a contextual perspective in a Sociodiagnostic critique (Reisigl, 2011). Thus, in this section, the purposes and effects of the intertextual discourses are assessed within the context of political and social environments. The purpose of the socio-diagnostic critique is to “expose manipulation in and by discourse, revealing ethically problematic aspects of discursive practices” (p. 51, Reisigl, 2017). The focus of this form of analysis is on the use of discourse as a form of social control, as well as on problematic discrepancies between discursive and other practices (Reisigl, 2017). Socio-diagnostic critique relies on background understanding of the social, political and especially historical context of the issue (Reisigl, 2017). Note that much of the contextual data – the social, historical and political contexts of the archive and thus of the discourses, is discussed extensively in Chapter 2 and provides background information that is relevant to this analysis. This section revisits some of the relevant context

that was addressed in the literature review, applying it specifically to the findings.

This critique is bounded by the assumption that health care services are a reflection and amplifier of the biases that are held by the most powerful policy-makers, which in turn are often reflective of biases that exist in society. Thus, societal biases can be and are reflected within policy itself.

Analysis of the data archive revealed two conflicting and co-existing discursive threads that seemed to form major themes underpinning and 'weaving' through much of the archive. These two discursive strands were named the Rights-Autonomy and Harms-Paternalist discourses. Upon initial analysis of these themes, it was evident that they are incompatible with one another: That there was strong potential for them to create scenarios in mental health service practice that resulted in diametrically opposing values and imperatives weighing on the same set of circumstances. At the same time, these discourses have the potential to situate serve providers in an uncomfortable position within this gap. The identity formed by the archive and imposed on the users of services is variably that either individuals are "dangerous" (to others or to their own wellbeing), unable to function (in terms of engaging in education or employment), vulnerable and requiring assistance; or alternatively, worthy of rights and full participation of society, including the right to make mistakes and bad judgments which may cause themselves harm, and that they may be "vulnerable". The nuances of these tensions in the discourse, especially in terms of the tensions between the concepts of "harm to self" (either in a self-violent way in one discourse or in the manner of poor use of judgment in the other discourse), as well as the overlapping use of concepts of "vulnerability" are further dissected in this chapter.

The key feature of these discourses is the manners in which they intersect with one another – and more strikingly – the manners in which they fail to intersect in a coherent way. The disparity between the two discourses

creates a space into which numerous problems fall, including exploitation. On analysis, within this space are tensions that pull in opposing directions.

Within this space between discourses, are identities which contain internal inconsistencies. These were identified as “vulnerable (but not vulnerable enough)” and “autonomous but dangerous” (as described in Chapter 4). These identities were identified as existing within a space of incompatible roles, wherein policy solutions become impotent in the face of the inconsistent principles embedded within. Thus, there are no actionable guidelines to address the issues that arise with non-criminal exploitation, as individuals are variably deemed too vulnerable to care for themselves or too fully autonomous to protect from “bad decisions”.

6.1.1 Ethically Problematic Aspects of the Identified Discourses

This section is intended to in part address and develop further discussion on the third research question: *What are the obligations – moral or otherwise - of mental service providers in addressing noncriminal exploitation of people with mental health problems?*

As discussed extensively throughout this thesis, people with mental health problems are described throughout the textual archive as a vulnerable population. While, as discussed in Chapter 2 and is discussed further in this chapter, the concept of vulnerability can bring its own ethical problems (Brown, 2015), it remains true that people with mental health problems are marginalized, stigmatized and face increased health and social issues as a result of their relative position in society. This by many measures means they fit within most understandings of “vulnerability”.

The Harms discourse further enhances the stigma and discriminatory attitudes that are at the heart of their vulnerability. Further, there are the implications within the discourse that in fact, the vulnerability of the person with mental health problems is as much related to their own internal characteristics as it is to external forces. Interventions that are prescribed

within this discourse are paternalistic, and involve the further restricting of rights, often with a notion of “their own good” (Dworken, 2020).

There are some ethically problematic issues with the Rights-Autonomy discourse as well, which bear scrutiny. The emphasis on autonomy of people with mental health problems can lead, practically speaking, to a de-emphasis on appropriate supports, especially in a resource-poor service sector. The scaling up of the Rights-Autonomy discourse, *without* a corresponding scaling up of recovery-oriented and person-centred, individualized supports for people with mental health problems, can increase a person’s vulnerability, via a reduction in a broad range of services.

These issues are similar to those concerns that many have voiced about the recovery model itself (as described in Chapter 2). This includes a concern that the recovery orientation might be co-opted by governments and medically-oriented mental health professionals who promote perceptions of recovery that in fact align with biomedical discourse (Price-Robertson et al., 2017). This has the effect of ‘masking’ biomedical programs with recovery language. There are also concerns that the recovery movement remains too ambiguous to provide meaningful guidance (e.g. Pilgrim & McCrannie, 2013). This ambiguity can require people with mental health problems to accept the status quo and find meaning in ‘the journey’ of recovery rather than in resolution to their suffering (Pilgrim & McCrannie, 2013). The privileged space occupied by these narratives can lead to a lack of critical engagement with the notions (Tilley & Cowan, 2011). Arguably, this uncritical inclusion of language of recovery and person-centred and rights-based care might well be fully evident within the Strategy. Care must be taken that Rights and Autonomy discourses are not deployed and uncritically accepted. A step towards this of course is ‘calling out’ the practice as inappropriate where it is seen. Tilley & Cowan’s (2011) assessment of the “privileged discursive space” is precisely the circumstance that must be avoided. Critical analysis must be accepted and allowed at all times. Criticism *especially* from system users must be encouraged and facilitated. Uncritical acceptance of the

language of recovery, person centred and rights-based care, in the absence of meaningful changes to policy and practice, can be not only harmful, but difficult to undo.

There are further ethical concerns regarding the existence of the gap between the discourses. There is space between the discourses for the negative aspects of each discourse to exist simultaneously. There are numerous paradoxes at the historical and societal levels that are reflected with these discourses. These paradoxes are also thus reflected and reinforced in political action, and manifest in the policies and texts that are examined in this thesis. These paradoxes are further reinforced within the mental health service system. As Swerdfarger (2016) describes, there is a great deal of power entrenched within the current psychiatric system and the hegemony of psychiatry within the mental health system. This represents a powerful force that will act to maintain the status quo.

6.1.2 Regarding the Strategy

Although Chapter 5 extensively covers the Mental Health Strategy, the centrality of the document in the archive means it is important to assess contextually.

The Strategy is only superficially committed to change in the direction of human rights. Human rights are utilized as a buzzword with no substantial policy guidance attached to them (see Chapter 5). Policy solutions within the strategy often relate to legal strategies and often relate to the criminal justice system. As such the problems as defined are not ones that lead naturally to solutions by increasing a focus on the rights of service users. The previous section discusses why this is a problem for service users: Namely, that utilising the *language* of change without adequate commitment to real policy and practice changes can actually mask the continuance of outdated practices, and mask the harm being done to service users.

As an examination of the discourses present in the textual archive reveals, the Strategy is, in truth, still written with a strong commitment to the status

quo, despite its discursive moves towards including rights-based principles. This misses the opportunity to develop real, radical reformation of systems which would ensure a true commitment to human rights would disrupt the status quo at a fundamental level.

However, what is offered by the Strategy is the enhancement or further development of the existing systems, rather than any fundamental restructuring of policy or practice. The only passing commitment to reformation is to the Adults with Incapacity Act, which is perhaps somewhat motivated by a political need to be seen to be responsive to a new set of human rights directives. This conclusion is supported by a lack of any mention of changes to any other legal frameworks such as to the Mental Health Act.

The foreseeable effects of this Strategy, as written, are minimal changes to the structure of mental health services in Scotland. There may be some redistribution of resources. There seems to be little to no motivation within the Strategy to commit to specific changes. The Strategy simply enjoins service providers to commit to a “rights-based approach” without defining what that means. This lack of definition, from a policy standpoint, will mean that the Strategy will be insufficient to motivate effective, coordinated change across the governmental and Third sector. This effectively reinforces the status quo, which as noted throughout this thesis, can be marginalizing and ethically problematic.

6.1.3 Regarding Exploitation

Exploitation is not seen to be a problem in the official narrative of mental health services. It doesn’t exist in the “official” discourse per se. In terms of public discourse, its presence is vague, expressed in varied language. In an attempt to explicate the problem as it is expressed in the texts, the following is offered:

There is provision for protection of people with mental health problems from abuse and exploitation in some laws (especially Adults with Incapacity Act

(2000), Support and Protection of Adults at Risk Act (2007); and in numerous human rights treaties, especially CRPD (cite). But as we noted in Chapter 4, when exploring documents directly addressing professional practice – namely the practice of people who are “relevant persons” per the mental health act, such as GPs, nurses, etc., exploitation is not referenced in any meaningful way.

One possible explanation for this exclusion is that the specific issue of exploitation is not in actuality seen to be a problem by the individuals who have developed the policies and guidelines that were examined: However, given the arguments outlined within Chapter 2, there is a general consensus that a problem does exist within this space.

Another explanation for this gap, and the explanation proposed here, is that that the problem falls in between the Harms-Paternalist discourses and Rights-Autonomy discourses. Neither set of discourses addresses it explicitly or implicitly. Both discourses however seem to allow for the possibility of it occurring, through appeal to the status of people with mental health problems as ‘vulnerable’. Thus, it may be that exploitation isn’t invisible within the archive as much as it is implicit, and lacks definition. Even when the definition of exploitation is expanded, as I do in the literature review (and further in Chapter 7) it is only defined within law, policy and practice guidelines as problematic in the case of criminal action, or when the individual lacks capacity or requires safeguarding.

However, if they do meet any of these criteria – if exploitation is criminal, if the individual is legally deemed not to have capacity, or is unable to safeguard themselves – then exploitation is defined as a concrete problem, though with little in the way of proposed actions available.

There is a deep complexity that exists in teasing apart the discourses around exploitation and mental health problems. As we see in both the literature and in the textual archive, people with mental health problems are defined as vulnerable persons; they are given the discursive identity of vulnerability. So

even if they are deemed legally “able to safeguard themselves”, this fails to capture the reality of the lived experiences of people with mental health problems. One of the central issues is that due to their discursively constructed position in society, they do not have equal access to self-protection from exploitation or abuse. Their options are limited specifically by factors such as their difficulty in forming social networks, by their constrained ability to find employment, and so on (see Chapter 2 for a discussion of these factors). Thus, the vulnerability of persons with mental health problems to exploitation is two-fold. First, they are vulnerable due to the nature of mental health problems and their marginalized position in society. But secondly, they have a greater vulnerability to the effects of exploitation itself. They (generally) would lack the resources and supportive networks to protect themselves from exploitative relationships, and similarly to escape exploitative relationships when they occur. They are more likely to rely on exploitative relationships due to whatever benefits that might accrue to themselves, despite the injustice of the situation.

Therefore, from the literature and from the discursive analysis, I conclude that the standard of “ability to safeguard” or “capacity to make decisions” is too restricted to offer any degree of protection for people with mental health problems from issues surrounding exploitation. The current standards of which people with mental health problems deserve special legal protections fails to capture the reality of the extent of vulnerability and marginality people with mental health problems experience in their daily lives.

Thus, the solution to noncriminal exploitation cannot be within the jurisdiction of mental health service providers and within the confines of the mental health act, which is where I initially believed a solution could be constructed. The discursive reality and identities present in mental health policy simply do not allow for such a solution in their present state. I conclude then that the issue – and therefore the solutions – potentially lie in the vulnerability and marginalization of people with mental health problems and the solution is to address that vulnerability.

The parameters of mental health services are discursively created as well, as evidenced by the analysis of the documentary archive. We as a society empower the government to provide the central services available to persons with mental health problems, and it is therefore through the government funded system that we need address this. Thus, these discourses which hinder the recognition of the unique vulnerability of people with mental health problems beyond the paradigm of disabled capacity/safeguarding, need to be changed.

The most effective place to start with that, then, is with the Mental Health Strategy. As will be discussed later in this chapter, the Strategy is a logical place to address serious reforms that begin to mediate the discrepancy between the discourses. As previously described, two major discourses are prevalent throughout the archive. Historical analysis demonstrates that movements toward human rights for people with mental health problems are often and largely grassroots based and/or arise in response to major human rights abuses such as WW2, institutionalization, and related abuses (as described in Chapter 2). The mental health strategy in its current form is insufficient to address issues that arise as a result of harm discourses because it remains too embedded in Harm-Paternalist discourses.

6.2 Prospective Critique

As with the sociodiagnostic critique, insights from the discourse analysis can be utilized to form a pragmatic, future-oriented perspective (Riesigl, 2011) in the form of a Prospective critique. As demonstrated in Chapters 4 & 5, various discourses can be tracked throughout the archive, and this gives us insights into the intentions and effects of the discourses. In particular Discourses can also be utilized strategically. Knowledge of the effect of discourse can be applied to encouraging and directing programs that are more likely to address the problems they claim to want to address. This means “letting go” of old commitments that hinder progress, and this means accepting that there will be pushback from power holders who are invested in the status quo.

The changes that discourse undergoes occur in sync with social change (Reisigl, 2017). Thus, importance of the current trends of social change in the direction of Rights-Autonomy – especially as represented within the advocacy and grassroots communities – cannot be understated.

6.2.1 Positioning Discourses in Mental Health Strategies

To this point, I have argued that the Harms-Paternalist Discourses are entrenched in the textual archive related to mental health services, and inasmuch as the Rights-Autonomy discourses are present, they are inhibited by the presence of Harms-Paternalist principles. Further, I have argued that the current Mental Health Strategy reflects a *fundamental* commitment to the principles that are consistent with the Harms-Paternalist discourses. Knowledge of the presence, nature, and effects of these discourses can help policy makers in the effective development of future strategies and policy directions that are better aligned with person-centred and rights-based care.

Discourses can be employed to manipulate social change (Wodak, 2002). That is, discourse is not always reactive to social trends: It can, and frequently is, strategically employed to actively make changes to public attitudes (Wodak, 2002). As previously described in Chapter 3, discourses and social change have a two-way relationship, and discourse can form social attitudes and identities as much as it can be shaped by and reflect them. It is therefore conceivable that desirable discourses can be actively incorporated within central texts, and thus given authority and power to create the changes that are desired. Old, marginalising discourses could be de-emphasized, with an end goal of complete removal from future strategic direction documents.

An example of how this might be done is by the appeal to expertise that is frequently deployed throughout the current strategy. In future Strategies, reference to the evidence-base should not be framed as purely scientific, or academic evidence. The “evidence” should prioritize the lived experience and

voice of people who use mental health services. Thus the appeals to authority becomes inclusive of lived experience. The expertise of people with lived experience in a document of this type will affect numerous changes in terms of discursive positioning of actors. Power will shift more meaningfully towards service users, as their voice will hold a more prominent place in the direction of future policy development. This should naturally lead to a shift away from the overwhelming power of service providers, especially that of the physician-expert. One would expect, over time, this will lead to a discursive shift away from Harms-Paternalist discourses that de-value the contributions and inherent value of service users, and hopefully lead to greater power over treatment decisions and milieu for service users.

Identification of the worth of people with mental health problems/ mental illness should supersede all and any references to potential criminality of those persons. Potential criminality should be referenced only within the context of broken law, rather than as a potential characteristic of people with mental health problems. As a corollary to this, law enforcement should be de-emphasized as a central figure in mental health service. This would shift power away from the judicial system and away from a carceral approach to society's relationship with mental health services. The shift of power should intentionally re-centre towards people who use services in a true person-centred and rights-based approach (see Chapter 7 for further exploration of "true" person-centred and rights-based approaches).

Note here that the strategy is explicit, despite centralizing a "rights-based approach", that there are no immediate plans for a radical reconstruction of strategic directions to be more in line with human rights - I specifically here emphasize the term "radical"; that is, a complete overhaul of the foundations upon which mental health services are based. Again, this idea is explored further in Chapter 7. This is almost surprisingly cautious, given that human rights are backed with the authority of law. Restructuring legislation should not be left to a "wait and see" approach, but must be prioritized so that Scottish mental health legislation is fully in line with existing international

human rights laws and principles. The changes in law will lead changes in policy and practice.

6.2.2 The Rights of People Who Use Services

It is incontrovertible to state that the rights of the people who require mental health services should be paramount when considering the design of those services. While there are obviously actions taking place in order to make this happen, it must be emphasized that the only way to meaningfully make these changes is with the involvement of people who use services. Their experiences and their perspectives on what makes treatment meaningful and effective is a central aspect of person-centred care (Ekman et al. 2011). It is therefore important that they be fully involved in policy development and service design in any system that desires to shift towards person-centred care.

Arguably, the rights of other interested parties – healthcare professionals, the public (especially represented by the forces of stigmatization) – have superseded the rights of people with mental health problems in the design of services until this point. This is very much seen in the analysis of the textual archive. This can be explained by the power differential described in Chapters 4 and 5, in which the role of service providers is privileged over the voices of the service user. This has led to the current situation in which many service users report feeling disempowered within the mental health service system (Cowan et al., 2011). There have been missed opportunities to engage with service users in this manner, and in fact despite rhetoric to the contrary, possibility of genuine engagement is limited at the government and policy levels (Cowan et al., 2011). This supports the concern that discursive identities of service users are entrenched to the point where even when governments sympathetic to social inclusion are in power (such as the New Labour movement, as described in Cowen et al., 2011) little is changed.

As duty bearers in rights-based care, individuals who develop the policies and practices governing mental health services are obligated to

constructively address the gaps that allow abuse and exploitation of people with mental health problems. Solutions are difficult to find without acknowledging the pervasiveness of Harms-Paternalist discourses in the upper echelons of power in the United Kingdom and Scotland.

6.3 The Need for Specific Interventions Targeting Exploitation:

As outlined in the previous chapters, notably in Chapter 4, exploitation exists within a gap in the major discourses within mental health service policy and practice. It falls between the features of discursively created identities. It thus is ambiguous, inconsistent and contains conflicting features. Individuals with mental health problems are simultaneously vulnerable to exploitation, but also are given enough autonomy that specific attention or interventions for any exploitative experiences that fall below the threshold of criminality are not considered.

In many cases “harm to self” is used as justification for removal of autonomy. This is true in the case of the mental health act, for example, where “harm to self” is one of the conditions wherein a person can be involuntarily admitted or treated. However, as discussed in Chapter 4, the notion of harm to self is also present in arguments to allow for more rights – that is, that people with mental health problems – despite their “vulnerabilities” should have the “right to make bad decisions”. The argument in this case is that harm to self is in fact a “dignity” that is afforded to all persons, and that people with mental health problems should be allowed to engage in such behaviours. What makes this position paradoxical however, is that in the case of people with mental health problems, it is selectively applied within the archive. It is applied to cases in which people are being harmed by damaging relationships for example (as described in Chapter 4), but is not often applied in the archive to cases of self-directed violence. And indeed, it is not applied at all to cases such as exploitative relationships.

While it is taken as true that all individuals should be free to make decisions and enter into relationships, including decisions or relationships that may entail harm to themselves, it is a principle of rights-based care that the most vulnerable people are prioritized in receiving services. In fact, this is a principle that is explicitly stated in the current strategy (p. 3).

These conflicting views of vulnerability and harm to self, which are simultaneously held by both “sides” of the rights-harm discourses, reveal a paradox of vulnerability, autonomy, and mental health problems.

As will be discussed further in the next Chapter, this issue requires some careful examination and nuance. But this issue deserves some attention in the context of broader issues facing mental health services vis a vis how services are delivered to the most marginalised and vulnerable persons. Exploitation reveals an interesting test case regarding the confluence of marginality, autonomy and vulnerability. While generally speaking, as a society it is a goal to improve the rights of autonomy of people with mental health problems, the case of exploitation reveals the difficulty of where the limits are between autonomy and provision of care and service that is protective.

Again, while this will be addressed further in Chapter 7, this paradox could benefit from careful examination of the concept of vulnerability and the nature of the appropriate interventions on the part of the state. This discussion could be fruitfully informed by a body of literature that strongly suggests that protection of vulnerabilities is in fact consistent with protection of rights, if one takes a more nuanced view of vulnerability. Fineman’s Vulnerability Theory (Fineman, 2021a), introduced in Chapter 2, for example conceives of vulnerability as “a socially and materially dynamic vulnerable legal subject, based on a richer account of how actual peoples’ lives are shaped by an inherent and constant state of vulnerability across the life-course” (Fineman, 2021b, para. 1). This conception of vulnerability is fluid, and requires understanding that vulnerability is a changing concept. Fineman further argues that that a responsive state has obligations toward the most

vulnerable and this responsiveness takes the form of social structures (Fineman, 2021a).

6.4 Recommendations for Mental Health Services in Scotland

In this section, recommendations for the Mental health services, as informed by the discourse analysis, Scotland are summarized.

6.4.1 The Strategy

Mental health services in Scotland, as they are delivered via governmental services, are underpinned by the Mental Health Strategy. In theory, all policies and initiatives undertaken by government funded services in Scotland should adhere to the Strategy as delivered. As such, it is a foundational document. At the same time, it is an aspirational document. It lays out what ought to be. Therefore, it has the potential to be removed from the limits of the status quo. This is the principle underlying the following recommendations.

Changing the discourses that exist within the Strategy, and resourcing the Rights-Autonomy discourses in the same way that elements of the Harms-Paternalist discourses are resourced, could have a meaningful impact on policy development for people with mental health problems who experience exploitation. The Strategy should be changed to reflect a genuine and meaningful commitment to rights-based services. This would necessarily entail letting go of old commitments to discourses that are marginalizing. If done correctly, a shifting of priorities towards the Rights-Autonomy discourse could lead to a more meaningful engagement with people with lived experience. Ideally, it could lead to redistribution of power towards those individuals, who would have greater say in their own treatment, and greater autonomy built into mental health service policy.

There is an opportunity here tod strategically employ argumentative discourse to emphasize principles aligned with the Rights-Autonomy discourse. These rights should be emphasized, consciously and strategically

- within the next Scottish mental health strategy. We must strategically embed rights discourse in policies governing care of people with mental health problems. Finally, we must strategically emphasize rights-autonomy discourses in mental health education, such that health care providers are conscious of the difference principles and how they can be enacted in frontline service provision.

The movement toward rights-based and person-centred care is intended to counter the long-standing systemic abuse of the rights of people with mental health problems. For this to occur in a meaningful way, The Strategy should be overhauled in its entirety to let go of principles aligned with the Harms-Paternalist discourses. These principles construct realities that impede progress toward generation of policies that respect individual choice and respect autonomy while also providing protection towards marginalized persons. As such, the new strategy needs to focus from the start, explicitly, on the rights of people who use mental health services. Violations of rights should be framed as such. Medical based care should be considered a last resort, with resources dedicated to community-based services. Coercive care should be viewed as a failure of other systems to succeed.

Police should not be named as a central figure in the new strategy. Involvement of police should only occur when laws have been broken. Enforcement of the mental health act as needed should be delegated to specially trained mental health professionals.

6.4.2 Redistribution of Power

The redistribution of power, away from the service provider and towards the service user, represents a substantial challenge, however there is a robust body of literature that already advocates for this exact thing (see for example, Swerdfarger, 2017; World Health Organisation, 2021, and so on). In this section, I discuss some of the issues that are of most relevance to the question of redistribution of power in the mental health service. In the end, only an intentional and sustained effort toward radical redistribution of power

in terms of treatment decisions will resolve the inherent tensions within the mental health services.

6.4.2.1 Who Holds Expertise? What is Evidence?

Power in the archive is closely related to who is deemed to hold expertise, who is in control of the evidence-base (as described in Chapter 2). This is relevant in determining who holds power within the parameters of mental health services. It is arguable that mental health service providers are deemed “experts” on the experience of mental health problems, as well as on the treatment of it within the archive. Subtle notions of the line between competent or incompetent for example requires judgements about how a person is experiencing the so-called symptoms of their condition. The mental health act and many other documents require such judgments from mental health service providers.

On this question, of who holds expertise and what constitutes evidence, advocacy groups have been in the lead of challenging traditional discourses. The importance of *lived experience* in both treatment – and vitally – in mental health research is a direct challenge to the notion that expertise and evidence should naturally reside with “professionals” or service providers. As discussed in the previous chapter, the Strategy fails to take up the opportunity to situate expertise and evidence more fully in the hands of service users and persons with lived experience. This is a missed opportunity that continues to reinforce the authority and power of service providers.

6.4.3 Meaningful Engagement of Rights-Autonomy Voices

Person-centred care, recovery-oriented and rights-based care are not new phenomena, and the various criticisms of the mental health service industry similarly are not new (in fact, many criticisms date to the early turn of the 1900s, as discussed in Chapter 2). This thesis has demonstrated that despite the long-standing existence of these care models; despite the long-established criticisms regarding mental health services; and despite the robust bodies of literature that support change towards Rights-Autonomy principles, mental health services remain firmly committed to Harms-

Paternalist principles. However, despite the fact that the Harms-Paternalist principles are firmly embedded in the archive, there is evidence, presented here current mental health service providers have internalized the messages consistent with the Rights-Autonomy principles. Further, they express genuine concern regarding the commitments to Harms-Paternalist principles.

The disparity between these facts is notable. As seen below, service providers are voicing strong support for more meaningful inclusion of Rights-Autonomy principles. At this stage, I can only speculate on why, despite this strong support, in the end these principles were not emphasized in the final form of the Strategy.

6.4.3.1 Scottish Government Consultations on the Strategy

The Scottish Government conducted consultations of service providers regarding the development of the Strategy. Many of the issues with the Strategy that were identified in this thesis as problematic were in fact directly or indirectly noted by the participants of these rounds of consultation, *prior* to the publication of the current Strategy.

According to the analysis of responses to the public engagement exercise (Scottish Government, 2016), respondents were concerned that the scope of recommendations in the proposed strategy did

> *"…not amount to transformation, and that the overall strategy lacks ambition or vision" (p 4)*

In response to this concern,

> *"…it was recommended that a vision and core set of values should be developed in partnership with those with lived experience" (p. 4)*

> *"There should be a much stronger focus on wellbeing" (p. 4)*

This is consistent with the observation that the Harms-Paternalist discourses remain prevalent within the strategy and that Rights-Autonomy discourses were lacking. The recommendations go on:

> *"This would mean a shift in focus away from service provision to the emotional health and wellbeing of Scotland's communities, and would require a major revision of the current strategy" (p. 4).*

Respondents noted that

> *"overall coverage is insufficient [in areas including] the impact of socioeconomic disadvantage, and the needs of the most marginalized and hardest to reach communities". (p. 4)*

> *"Another area on which a number of respondents commented was the human rights based approach. It was sometimes suggested that this needs to be more firmly embedded and should be "threaded through" the whole Strategy, rather than be seen as one of the priorities." (p. 4)*

Other areas respondents wanted to see more emphasis included:

> *"How experiencing inequality can contribute to or cause poor mental health"; "addressing the needs of more vulnerable populations; the rural dimension; tackling stigma and discrimination; employment and employability; and the links with alcohol or substance misuse". (p. 4)*

One might note that, according to the report, the participants do not mention the need to scale up medical resources or increase the role of medical professionals or police services, but rather referenced a need for generally improved resources for staffing. They also highlighted the need for increased focus on other approaches to service. In particular, recovery focused care was mentioned explicitly (p. 5).

Participants recommended a need to acknowledge the role of generalist care. It is of note from a critical analysis perspective, that this *does* make its way through to the final strategy, in the form of recommendations for increased mental health training for GPs. This reinforces the importance of the medical model and approach to mental health problems in the Strategy. It reinforces the power of medical providers, and increases funding to medical interventions. It cannot be emphasized strongly enough that of the many recommendations made by the participants in the review, the interventions focused on medicalization of mental illness are the only ones that make it through to the final strategy in any substantial form.

When participants were asked what their "final vision" includes in 10 years' time, these themes were identified in the report (Scottish Government, 2016):

> *Reduced stigma/discrimination*
>
> *Wellbeing and early intervention/ prevention as a focus*
>
> *Tackling inequality*
>
> *Whole systems approach which is intrinsically person-centred, flexible and has moved away from overly medicalized models of care (p. 10)*
>
> *Integrated and equitable services*
>
> *Self management as a component of tiered approach to care, which entails giving people the resources to manage their own care*
>
> *Recognition of vital role of carers and families*
>
> *Employment*
>
> *Outcome focused evaluation of services*

> *Co-production and the lived experience: "The vital importance of involving and listening to those with lived experience has been a common theme running through many of the responses" (p. 11) "The idea of 'service user involvement' will have been replaced by the user-led participation model" "Services will reflect and act upon the views and experiences of both those using services, as well as their families and carers" "This will help move toward… skilled user led peer support". "To reap the full benefits of this cultural shift, outcome measures will focus on indicators of wellbeing and the development of those measures will be strongly informed and influenced by people with lived experience of mental health" (p. 11)*

These quotations from the consultation are presented as evidence that service users have internalized the importance of Rights-Autonomy discourses, and express discomfort with Harms-Paternalist principles. They express desires for greater inclusion of people with lived experience. They would like less emphasis on medical care and more emphasis on rights of patients. The expressed vision of future mental health service is, in fact, well aligned with the conclusions of this thesis. As such, it is impossible to conclude that people who are currently working within the system are fully complicit in the entrenchment of Harms-Paternalist discourses. Further, it is disappointing that this vision failed to make its way into the final form of the Strategy. Speculation as to why this came to be is beyond the scope of this thesis, however it is certainly notable that the vision presented here represents a shift of power in decision making and service design, away from service providers towards people with lived experience. However, moving forward, there should be a serious commitment attending to the concerns and voices of people who work in mental health services at the point of service provision.

6.4.3.2 A Word of Caution on Meaningful Engagement

In many ways, both the Rights-Autonomy Discourse and the Harm-Paternalist Discourse still speak *of* people with mental health problems. While many aspects of the Rights-Autonomy Discourse focus on less marginalizing, more inclusive ways of speaking of people with mental health problems, there is a long way to go before people with mental health problems can speak of themselves in a way that holds power in society – wherein their voices hold more power over the way services are designed and delivered. This vision though, is something that should be held as an ideal end point of changes instituted within mental health services. In enacting this, is important that policy makers be aware of continuing harmful patterns of speaking "of" rather than "with" people with lived experience. As discussed in Chapter 4, "othering" is the process of ascribing identities to a minority group, often in a manner that is damaging or pejorative. A feature of "othering" is that those who are "other" are often spoken "of" rather than "to" or "with" (Fine, 1994). Otherhood is constituted not only of how people speak to and with one another, but is engrained in systems and processes (Katsiaficas et al., 2011; Fine, 1994). This process of othering needs to be actively acknowledged and avoided in engagement exercises.

6.5 The European Convention on Human Rights

One distinct issue that has not yet been discussed in this thesis is the current unsettled, status of the United Kingdom's relationship with the rest of Europe. While this issue is beyond the scope of this thesis, it does bear brief mention in discussions of future directions of mental health services. This is especially true as Scotland desires a fuller integration of human rights in mental health services.

The full scope of the economic, social and political fallout from Brexit, as of the time of writing, remains largely unknown, though certainly there are strong indications that the United Kingdom is on a trajectory of continued struggles for the foreseeable future. One issue that has arisen recently is the status of the UK in relation to the European Convention on Human Rights

(Green, 2023). The intention is to re-assert national authority over decisions that may have components related to human rights, independent of influence from the EU. There is a significant concern that the ECHR stands as one of the most important human rights documents in the Western world (Hunt, 2016) and to abandon it would be a symbolic step away from the sorts of commitments in the Rights-Autonomy discourses. The ECHR certainly stands as a touchstone when policy makers refer to “human rights” and commitments to “human rights”. The removal of the UK’s signatory status to the ECHR may have unknown consequences to the human rights commitments embedded in the Archive. Much work will need to be done to follow up on the possible impacts this may have.

6.6 Key Points

In this Chapter, a discussion of the results of the discourse analysis and literature review is presented with a critical perspective on the current and future status of mental health services in Scotland.

The entrenchment of the Harms-Paternalist discourses in mental health service, and especially in the Strategy introduces a number of ethically problematic issues. Most importantly, it entrenches marginalising identities for individuals with mental health problems and power structures that continue to privilege professionals at the expense of service users.

In examining potential future actions based on this information, there is evidence that the Scottish Government missed an opportunity to meaningfully address the presence of Harms-Paternalist discourses, and that service providers have already provided the government with a vision that is well aligned with Rights-Autonomy discourses.

Chapter 7 Exploitation in Mental Health Service Policy

This study was born from questions concerning noncriminal exploitation of individuals with mental health problems. It transformed over time into a critique of the current status of the mental health system in Scotland. It emerged through the iterative data collection and analysis that noncriminal exploitation is a case study of a problem that exists in a “grey zone” created between the two prominent, incompatible discourses that dominate and drive mental health policy in Scotland, and establish the legal, policy and moral norms that guide professionals.

The initial questions on exploitation led to an analysis that revealed a larger problem with mental health service delivery in Scotland. In my numerous attempts to juggle the issues to solve the problem of exploitation in a meaningful way, it emerged that there is too large a systemic issue, which hinders any attempt to provide an adequate solution within the boundaries of the current system design.

This Chapter focuses on the second aspect of the original aims of the research project, which was to explicate how service providers might be given tools to address non-criminal exploitation in practice.

While discourse analysis revealed an issue in texts related to policy and practice in mental health services, this analysis reveals how complicated issues related to vulnerability and exploitation may lead to some clarity on moving mental health services forward in a manner that is more genuinely person-centred and rights-based.

In this Chapter, a new methodological approach is introduced, which is Bacchi’s “What is the Problem Represented to Be” or WPR approach (2009), which can be used for the purpose of policy analysis in health care (Bacchi, 2016), making it an appropriate methodology to use here. This section is focused on specific policy recommendations for the “problem” of non-criminal

exploitation of people with mental health problems. This is used to illuminate a pragmatic way forward in terms of articulating exploitation in a way that will be useful in formulating policy around it.

7.1 The relevance of the discourses to noncriminal exploitation

Understanding the interactions between the Harms-Paternalist and the Rights-Autonomy Discourses provides a framework for understanding how exploitation of people with mental health problems can occur. As discussed in Chapter 6, exploitation reveals a paradox between notions of vulnerability, marginality, harm and autonomy that are embedded within the discourses in the textual archive. It reveals tensions in the intersections of discourses of marginality, autonomy and vulnerability. While it is a goal to improve the rights of autonomy of people with mental health problems, the case of exploitation reveals the difficulty of where the limits are between autonomy and provision of care and service that is protective.

The emphasis on principles aligned with Harms-Paternalist discourses and the simultaneous encouragement of autonomy leaves people who might be vulnerable to exploitation with inadequate protections. The discourses clarify the question of how there are no existing policies to mitigating the heightened risk of exploitation of people with mental health problems, nor are there procedures that outline how mental health service providers may intervene should such cases arise. Indeed, even in the literature, there is nothing addressing this risk beyond acknowledging that it is indeed heightened.

Further, people with mental health problems who are exploited are members of a group that are systematically “othered” – as described in Chapter 4. Their identity, as defined within the Harms-Paternalists discourses, is that of a person who is potentially harmful, and not someone who contributes to society. This is one mechanism by which people with mental health problems are othered, and it is a mechanism that is embedded in much of the texts

related to mental health services, due to the othering effects of the Harms-Paternalist discourse, as identified in Chapter 4.

I argue, based on an analysis of vulnerability in the context of mental health services, that exploitation is best understood as a systemic issue that plays out at the individual level. This dichotomy could actually be protective of people who are exploiters; in that systemic issues are difficult to 'untangle' at the individual level and individual responsibility might be ascribed to systemic issues. As discussed in Chapter 4 there are conflicting statements made in the archival texts about the status of people with mental health problems as both vulnerable but people who generally have capacity. The fact that people with mental health problems are not necessarily disabled, that they are autonomous rights-bearing persons, means that they explicitly reside in a space where they are "allowed to make bad decisions" – this includes participating in exploitative exchanges. As such, this 'disempowers' health care professionals who might want to intervene on their behalf, to support making decisions that might prevent exploitation. This is a remarkably complex subject, as one will recall that marginalized people might often make decisions to remain in exploitative circumstances in part because they might actually be benefitting from them, though in an imbalanced way. The disempowerment of health care professionals then comes not only from explicit direction to allow capable adults to engage in "bad decisions" – even exploitative ones – may also be causing some degree of harm themselves by attempting to prevent the exploitative relationship. For example, should we return to the situation of a person with severe and enduring mental illness who is exchanging sex for a place to live: To disengage that person from that relationship could potentially result in the loss of housing for the person with mental health problems. And housing for people with mental health problems is an extremely precarious situation. This example illustrates why exploitation in these situations is a systemic issue that plays out on the individual level.

The awareness or visibility of a person's mental health problems may be a contributing factor, but the vulnerability created by the mental health

problems – the lower income and resources, the lack of social engagement, etc, are what create the fundamental conditions for the exploitation to occur. Thus the exploiter doesn't necessarily need to be aware of the fact that mental health problems is present to leverage the vulnerability created by it. However, it is vital to recognize that this vulnerability is generally a result of conditions created by social pressures and perspectives on people with mental health problems, rather than necessarily an inherent trait held by persons with mental health problems.

Similarly, the stigma associated with mental health problems contributes to both the vulnerability of the individual with mental health problems (Clement et al., 2013). Interestingly, given the presence of stigmatizing messages embedded in the Harms-Paternalist discourses, and the association of these messages with messages that exist in the public (e.g. the media, again as described in Chapter 4), the stigma may contribute to the mindset and perceptions of people who are exploiters in a relationship. That is, if they ascribe to beliefs about mental health problems that are inherent in the Harms-Paternalist discourses – even unconsciously - then they may hold perceptions that people with mental health problems are potentially harmful individuals who are not deserving of full respect of their personhood or rights. Or, alternatively, that they are not capable of making their own decisions and thus others may take a controlling or paternalistic position in relation to the exploitee.

Mental health service providers are caught between the two major discourses and confronted with the conflicting identities discursively attributed to service users. As identified in my analysis, mental health service policies often reinforce both discourses, with an emphasis, generally on the Harms-Paternalist discourses. The Strategy reinforces Harms-Paternalist Discourses and makes no appreciable gains in terms of rights of people with mental health problems.

7.2 Problematizing Exploitation

7.2.1 Defining the Policy "Problem"

In this section, a new methodological approach is introduced, which is Bacchi's "What is the Problem Represented to Be" or WPR approach (2009), which can effective be used for the purpose of policy analysis in health care (Bacchi, 2016), making it an appropriate methodology to use here. This section is focused on specific policy recommendations for the "problem" of non-criminal exploitation of people with mental health problems. This is used to illuminate a pragmatic way forward in terms of articulating exploitation in a way that will be useful in formulating policy around it.

Bacchi's approach to policy evaluation is Foucauldian and post structural in nature, which makes it an appropriate fit for the analysis undertaken in this thesis. It centres around the question "what is the problem represented to be"? (Bacchi, 2016). Problems, per Bacchi, are not external to the process of policy development, they are "produced as problems of particular kinds within policies" (p. 1) – Bacchi states that policy statements contain a particular representation or type of problem.

In a poststructuralist approach, one can argue that problematizing will happen in any form of policy development. Mindful problematization of the issue of exploitation in mental health services will naturally lead to the types of outcomes that are in alignment with rights based and person-centred services. The problematization of this issue can be informed by the presence of the Harms-Paternalist and Rights-Autonomy Discourses, and be intentionally designed so as to "steer" outcomes towards the Rights-Autonomy, and disincentivize initiatives towards the Harms-Paternalist Discourses. Policy statements can be written such that Harms-Paternalist Discourses are intrinsically linked to the issue of exploitation.

As previously discussed, while people with mental health problems are a vulnerable group in and of themselves, they are not generally afforded special protections unless they meet the criteria for other forms of "disorder",

such as loss of capacity or intellectual disability. While some point to the CRPD as an avenue for the protection of rights of people with mental health problems it is not clear that all people with mental health problems fall into this category, and indeed, as discussed in Chapter 5, there is reason to believe that many policy makers make clear distinctions between mental illness, mental health problems and mental disorders. Thus the problem to be addressed with any policy to be developed addressing exploitation is that people with mental illness are especially vulnerable to exploitation within their community and within their relationships. This vulnerability is a feature of their marginalized and stigmatized status in society. Marginalization and stigma leads to social isolation as well as to poor access to resources. Both of these further exacerbate their vulnerability to exploitation. Exploitation is a human rights violation, and service providers have obligations to act to assist people with mental health problems and protect them from exploitation. However, there are no resources, policies or defined procedures currently directed at this issue.

In Table 7.1 (below), I apply Bacchi's WPR approach to examine the problem of noncriminal exploitation of people with mental health problems. As one can see from the table, Bacchi's problematization approach provides a framework that ties together the issues that have been discussed in this chapter. It allows for a framing of the issues in a coherent way that lends itself to policy development.

From utilizing the framework, we can determine that exploitation can be "problematized" (Bacchi, 2016) in an effective way that then can lead to targeted interventions. Potential interventions will then be discussed below.

Table 7.1 Bacchi's Problematization	
Q1: What's the Problem Represented to Be?	The problem is represented as the enabling of exploitation of persons with mental health problems: By enabling, I refer to the allowing to happen, and also to the furthering of discourses that are marginalizing and perpetuate harmful stereotypes. Thus the problem is not the exploitation per se, but the conditions that allow the exploitation to exist in the first place. This places the realm of intervention not on individuals – exploiters, people with mental health problems, even individual service providers – but at a societal level. The noncriminal exploitation of people with mental health problems is a human rights violation. It is a violation of the rights of people to not be subjected to cruel treatment, to live free from abuse and discrimination (ECHR), and it interferes with an ability to attain the maximum attainable level of mental health (WHO Constitutional Right to Health).
Q2: What presupposition and assumptions underlie this problem?	Individuals with mental health problems are vulnerable to exploitation. This vulnerability is a feature of the systems and discourses that represent them as non-productive members of society, as lesser, as potentially dangerous or criminal. Measures that attempt to correct the problems of marginalization by empowering people with mental health problems may unintentionally end up furthering the space in which exploitation can occur.
Q3: How has this representation of the problem come about?	This representation of the problem is the result of competing discourses embedded in mental health service policies, and arising from numerous social and historical dynamics that are outlined in Chapters 2 and 7.
Q4: What is left unproblematic?	Current conceptualizations of exploitation often see the exploitation as unproblematic, due to a) the autonomy of people with mental health problems and b) the legal nature of much of the exploitation – thus the problem is framed as "bad decisions" by people with mental health problems, rather than "exploitation or coercion" by people leveraging vulnerability. In this proposal: Mental health problems in and of itself is left explicitly unproblematic. The problem is framed as the oppression and marginalization of people with mental health problems. There is no assumption that the vulnerability of people with mental health problems is related to their symptoms. Further, it is not problematic that people with mental health problems are often un/underemployed, per se. The un/underemployment of people with mental health problems is in fact merely something that might contribute factors to the harmfulness of noncriminal exploitation.

Q5: What effects are produced by this representation?	This representation has the effect of turning the direction of intervention away from people with mental health problems as people who need help, and towards the social factors that lead to their vulnerability as needing to be fixed.
Q6: How and where has this representation been produced/disseminated and defended?	Similar problematizations have been produced, for example, with the CRPD and associated materials.

The analysis of the archive using Bacchi's problematization reveals a number of issues that could be used to target pragmatic intervention. Most meaningfully, is the principle that mental health problems could and should be left 'unproblematic' in and of itself. If the 'problem' is defined as societal treatment of people with mental health problems, then interventions should prioritize that issue specifically, rather than addressing the ways in which people with mental health problems exist within a stigmatizing society. If vulnerability is seen to be a feature of systems, is fluid and most importantly relational, then it is not individual traits that should be the target of interventions.

An example of how this might play out in policy is for example the focus on employment for people with mental health problems as seen in the Strategy. Such a focus tends to be on the management of skills and symptoms of individuals with mental health problems so they become 'employable'. If the systemic stigmatization of people with mental health problems is problematized, then the target of intervention would become education of employers.

7.3 Policy Recommendations Regarding Exploitation

The broader issues uncovered in this thesis are deeply entrenched and systemic. However, in the previous section, an attempt to "problematize" the specific case of exploitation using Bacchi's (2016) WPR framework was executed. As such, from that analysis and identification of stakeholders, in this section I will present some potential policy recommendations. It is important to emphasize here that these policy recommendations by no means intend to address the broader issues uncovered in the discourse analysis, but represent an attempt at addressing the narrow issue of noncriminal exploitation of people with mental health problems, and the potential role of professionals who deliver services in addressing this issue.

While this thesis argues that a true solution can only be found in a radical reconstruction of mental health services in Scotland, there are some potential avenues of action that might target the issues of exploitation of people with mental health problems in the shorter term. Three such suggestions are made: 1) Conducting an awareness campaign to facilitate a change in public discourses; 2). To clarify and enforce legal protections of persons with mental ill health; and 3) Establish a nongovernmental advocacy group providing supports for people with mental health problems in unsafe and harmful circumstances.

7.3.1 Representation in Media

As discussed in Chapter 2 and briefly in Chapter 6, media representation of people with mental health problems can play a central role in discursive construction of their identity, and therefore can influence public attitudes and perceptions of them, as well as of themselves in the form of self-stigma (Diaz-Mandado & Perianez, 2021) and their place in society. Public attitudes must be taken into account when assessing policy changes (Herman, 2013), and the sensitive and marginalized identities of people with mental health problems make this especially important. Large scale changes in health service policy without a supporting public can in fact lead to backlash against people with mental health problems (Mehta et al., 2009). It should also be noted that in many ways, service providers are themselves members of the public and subject to many of the same biases and stigmas as the general public.

7.3.2 Awareness Campaigns

Awareness campaigns, or social marketing campaigns, are an effective tool in changing public attitudes and behaviours (Bordarie, 2019) at the population level (Stead et al., 2019). There is strong evidence that marketing campaigns can shift social representations, or the common understanding that people have of a phenomenon (Bordarie, 2019). This can lead to fundamental shifts in the attitudes and behaviours of social groups. Media campaigns have also led to increased knowledge and awareness of issues

among populations (Young et al., 2018). And media campaigns have had some success in reducing stigma (Sampogna et al., 2017) and prejudice (Clement et al., 2013) against people with mental health problems. It has also been shown to increase the usage of mental health service (Collins et al., 2019).

As was extensively discussed in Chapters 4, 5 and 6, social attitudes have a reciprocal relationship with policy. Further, we have seen that past shifts in social attitudes have led to more open policies regarding a marginalized group of individuals. One example is the treatment of individuals with HIV/AIDS diagnoses. Mass media was integral to the global response to HIV/AIDS (Hutchinson & Yukich, 2007). Media campaigns targeted awareness and information sharing, promotion of healthy behaviours (ibid.). It also targeted attitudes, stigma and discrimination against people with HIV/AIDS (Hutchinson & Yukich, 2007). Media campaigns were credited for measurable reductions in the incidence of HIV infections in numerous countries (Hutchinson & Yukich, 2007; UNAIDS, 2004) as a result of improved social attitudes and acceptance, and also the adoption of healthier behaviours and habits in the general population.

Thus shifts in social attitudes, beliefs and the reduction of stigma can have a powerful effect on the behaviours and wellbeing of people with mental health problems. Reduction in stigma and discrimination can have a ‘humanizing’ effect on individuals as well as “demystifying” mental health problems (Hocking, 2003), which would make them less likely targets of abuse or exploitation, and will in turn reduce their perceived and actual vulnerability.

It should be noted that media campaigns targeting mental health problems however need to be conducted with some degree of caution. There is criticism for example of media campaigns that have the potential to worsen discrimination against certain types of people with mental health problems, or people with certain diagnoses (Robinson et al., 2019; Budenz et al., 2020). Many media campaigns target “mental illness” or “mental health” rather than specific diagnoses. As discussed in Chapter 2, there is some evidence that

while stigma is reducing around mental health and illness, there is evidence that stigma remains strong in relation to specific diagnoses – bipolar disorder for example (Budenz et al., 2020), or schizophrenia (Robinson, 2019); in fact research has demonstrated that schizophrenia is one of the most negatively viewed conditions due to misperception (Robinson et al., 2019).

A study published in 2000 (Crisp, et al., 2000) elicited the following regarding the differences in perceptions regarding mental illnesses:

> *Responses differed between the seven disorders, and the differences were most apparent in answers to questions about dangerousness, attribution of blame, ability to pull themselves together, response to treatment and prospect for recovery.*
>
> *Schizophrenia, alcoholism and drug addiction elicited the most negative opinions. (p 5).*

This particular finding (though dated) is included here due to the specific finding that people with different disorders are viewed with more or less empathy, and that some disorders – especially schizophrenia, alcoholism and drug addiction – seem to carry a greater perception of moral failing among the general public. Further, there is evidence that people with psychosis are stereotyped as dangerous and unpredictable, with studies showing that the general public “express the greatest desire for increased social distance from people with psychosis” (Morrison, et.al, 2016, p. 5). These findings are consistent with surveys from Scotland which found that people with schizophrenia are viewed with the highest rates of negativity (Scottish Government, 2014).

This difference in perception between different forms of mental health problems is supported by other studies demonstrating that illnesses such as depression are seen more favourably and treated with greater sympathy (Reavley & Pilkington, 2014).

Further studies are demonstrating that trivialization of mental health problems is also prevalent (Robinson et al., 2019). That is, the minimisation of the seriousness of mental health problems, which manifests in conceptualisations of some mental illnesses as being easier to “acquire, suffer with, or treat” (Robinson et al., 2019, p. 52). This can be a form of stigmatisation (ibid.). Another form of trivialization can take the form of the mis-use of phrases related to mental health problems, such as when people use the phrase “OCD” to describe personal preferences for cleanliness, which is becoming increasingly common (Pavelko & Myrick, 2016).

These variations in the perceptions of people with mental health problems are vital to understand when developing media campaigns aimed at mitigating harmful social beliefs and behaviours. Arguably, some of the positive good will that “mental illness” has earned has in fact come at the expense of people with certain forms of mental health problems such as schizophrenia, psychosis, bipolar disorder and substance use disorders. This raises the spectre again of the issue of the potential mis-use of concepts of vulnerability, which can be intertwined with perceptions of “deservability” (Brown et al., 2017; Brown, 2015) as was discussed in Chapter 2. Any campaigns must be careful to avoid reinforcing tropes of some illnesses being more or less deserving of public sympathy – and therefore deserving of full rights – than others.

7.3.3 Anti-Stigma Campaigns in Scotland: “See Me”

In Scotland, one of the more prominent anti-stigma campaigns was the “See Me” Campaign that launched in 2002 (Mehta et al., 2009). This campaign was multi-media, cinema advertising, outdoor posters, and leaflets in public spaces. It also incorporated an interactive website. It was noted by Mehta et al. (2009) however that at the same time this campaign launched, there was an almost unprecedented wave of negative news attention around people with mental health problems, liked at the time to reform of mental health legislation taking place in England. At the time, many news organizations, especially tabloids, reportedly dedicated attention to the linkages between

mental health problems and violence (Mehta et al., 2009). As such while there were some early positive results in perceptions among people in Scotland as a result of the ”See Me” campaign, much of this was potentially undone by the larger political events occurring at the time (Mehta et al., 2009). This further illustrates that while anti-stigma campaigns can have some positive effects, they are by no means sufficient to shift public attitudes. Further, any shifts that may occur as a result of anti-stigma or awareness campaigns are sensitive to being reversed by other events.

7.3.4 Appropriate Representations

While awareness campaigns are a useful tool, as discussed above, they have been met with limited success in some cases, including in Scotland. Other methods of engaging the public and shifting perceptions must be described as well. One of these methods can be appropriate representations in and across various media. As noted above, campaigns in and of themselves can be met with limited success, and can risk entrenching systemic perceptions.

Media representations of people in marginalized groups are highly impactful, not only on community perceptions (as discussed above), but also on self perception (Steinberg, 2021). Internalized stigma can result from viewing media in which ones own marginalized group is poorly represented (Steinberg, 2021). Internalized stigma can lead to feelings of hopelessness, and can interfere with seeking help (Morrison et al., 2016). Morrison et al. (2016) note of mental health service users that

> *Service users have identified stigma, in particular media images, as a negative influence on suicide (p.2)*

That is, media representations have a powerful impact on internalized as well as external stigma experienced by persons with mental health problems. On the opposite hand, positive media imagery can be associated with reduced internalized stigma (Steinberg, 2021).

As with the discussion of grassroots activism, there is a good deal of more positive and realistic depictions of mental health problems that come from individuals who have experienced mental health problems. Authors such as the poets Jo McFarlane (https://adisorder4everyone.com/bio/jo-mcfarlane/) or Janine Booth (https://www.janinebooth.com/) strive to portray mental health problems or mental diversity in positive but realistic ways,. Both authors engage the public and advocate for improved mental health services.

This is a further opportunity for government services to engage with media in a positive way. Some future steps might be to support stigma-challenging representations of mental health problems in creative media, beyond what they traditionally engage in with awareness campaigns.

7.3.5 Clarification of Legal Protections and Obligations of Service Providers

As has been discussed in Chapter 2, legal protections for people with mental health problems and mental disabilities or disorders exist. However there is a great deal of confusion among practitioners about what laws, frameworks and guidelines apply to which categories of persons. As described in Chapter 2.4, there is a lack of clarity around the different language used in legal frameworks and guidance. Further, front line workers express confusion about what their own obligations are and to whom. This is further exacerbated by the issues surrounding the definitions of mental illness, mental ill health, mental disability and mental disorder. For example, the CRPD has the potential to offer protection for certain individuals, but it's not entirely clear that it applies to all persons with mental ill health. The lack of clarity between terms like "mental disorder" vs "mental illness" leads to confusion for individuals who must enact policies and procedures (Goldman & Grob, 2006).

Similarly, the Mental Health Strategy cites the Adults with Incapacity (Scotland) Act, 2000 as being protective of human rights of people with mental health problems, but again it is unclear to who the Act actually applies in many situations, and in many cases people are excluded from it (as seen

in Chapter 4) even when their wellbeing is threatened. But with that said, Scotland does set a positive example with the Mental Health Act. This Act specifically defines vulnerability inclusive of mental health problems (Williams, 2002). This and other laws specifically protect other vulnerable groups such as older adults or people with intellectual disabilities from abuse and exploitation.

When examining public law protecting vulnerable persons in Europe/UK, the central document is the European Convention on Human Rights (Williams, 2002). As this has been ratified into law, the state has a positive obligation (Williams, 2002) to avoid violation of this right – i.e. ensuring that people, especially vulnerable people (ibid) have adequate protection from inhuman and degrading treatment. However, with the ECHR under threat in the UK, this is a good opportunity to revisit the other laws that offer protection to people with mental health problems.

It is extraordinarily difficult even for people familiar with laws to understand all of the legal requirements and rights that individuals of different groups have access to. As noted in Chapter 2, there is evidence from many fields that practitioners often struggle with interpreting legal frameworks (Levi & Portwood, 2011; Levi & Loeben, 2004) . Therefore while legal protections in fact do exist for people with mental health problems, and these legal protections can and do offer protection from abuses such as exploitation, it is clear that confusion among practitioners, as well as conflicting discourses embedded within policies, leads to many circumstances that leaves individuals with little support in harmful circumstances.

It seems then that clarity of the laws in these cases would be beneficial. To this end, it would be beneficial for the Scottish Government to commission an investigation of the laws, with an eye to examine vulnerability, abuse and exploitation of people with mental health problems, and the laws available to them. Clear guidance from the Scottish Government is needed, outlining the various legal frameworks, and more importantly, how practitioners are to interpret those frameworks in ‘fuzzy’ situations such as noncriminal

exploitation and not-easily categorized vulnerable groups. I do specifically argue in this instance that such guidance should come from the Scottish government. It is apparent from both the literature review and from the analysis of documents that the Scottish government provides an overarching authority over mental health services. Whilst ideally other organizations might be able to provide such guidance, if the Scottish Government fails to enact principles that are more effectively aligned with the Rights-Autonomy discourses identified here, then other organizations will struggle to make meaningful changes that will impact the lives of people with lived experience, especially for those people who live with severe and enduring mental illness, who rely in substantial ways on government services.

7.3.6 Sponsorship of advocacy group

A potential solution might entail the creation of a non-governmental advocacy group aimed at prevention and assistance. This thesis is focused on potential actions of the Scottish Government, and as such a non-government organisation might seem an unintuitive fit. That said, there is some evidence of success (see for example, Aby & Gonzalez Benson, 2021; Fröhlich, 2012) of models of service groups that run independently of the government, but were initiated by and benefit from an early relationship with the government. Transformative change programs are valuable, especially in response to needs where inequality and oppression are implicated (Aby & Gonzalez Benson, 2021).

While reformation needs to occur throughout the health services sector, the insights gathered in this study lead to the conclusion that advocacy organizations are the most effective at responding to the needs of oppressed groups meaningfully, and in a way that does not perpetuate the oppression. Consistent with recommendations made in Chapter 6, advocacy organizations should be granted leadership roles and engaged meaningfully. Evidence demonstrates a valuable role for such organizations in providing direct service in targeted areas. However, the challenge faced by such organizations, especially organizations that provide direct service to

oppressed groups, is lack of funding (ibid.). This is where the cooperation of the government becomes vital. Evidence further shows (Aby & Gonzalez Benson, 2021) that such organizations can effectively be initiated through and funded by a government agency.

Thus the Scottish government could sponsor the creation of a third sector or NGO advocacy group that is aimed at prevention of exploitation and assistance of persons living within these circumstances. This group would ultimately become self-governing and eventually aim to be externally funded.

There are some caveats however: Such an organization must be truly independent of influence by governmental bodies or representatives. This is important not only for maintaining a commitment to Rights-Autonomy Discourses, identities, and opportunities, but also for the trustworthiness of the organization. Further, it must employ individuals who are legitimately invested in the rights of people with mental health problems, and be meaningfully advised – if not led - by people with lived experience of mental health problems and the resulting marginalization. As the focus of this organization will be noncriminal exploitation, there will be a need to carefully define the Terms of Reference, and to ensure clear guidelines around how and where the threshold between criminality and reportability lie. People who work with exploited persons will likely be mandatory reporters, as it is likely they will be working with and encounter vulnerable persons who are being exploited in a criminal sense. Careful legal guidance will be required.

7.3.7 Radical Reformation

In numerous parts of this thesis, reference is made towards a “true” vision of rights-based and person-centered care. This concept deserves some attention here.

The conclusions of this thesis are that human rights must be given the primary space in mental health strategy and policy. The focus must be not only the right to autonomy but also the right to maximum attainable level of health and right to safety (World Health Organisation 2017). Patriarchal

commitments to discourses of the dangers posed by people with mental health problems, and to carceral and coercive interventions, must be removed for this to happen (World Health Organisation, 2021). This ultimately means a radical re-constructing of the principles on which mental health services are based, and disruption of power structures that give primacy to medical professionals and especially to police within mental health services.

This shift ultimately requires an acknowledgment that certain elements of mental health services are not simply old fashioned, but that continued commitment to them actively impedes and counters the ability to propose actions that are protective and promoting of human rights in persons with mental health problems, and who use mental health services.

How does one define radical reformation of mental health services? While there have been numerous actions (and successes) that have improved the inclusiveness of services, change remains slow. There have been major missed opportunities for fundamental change as well (Cowan et al., 2011), with policy makers opting to make incremental change rather than fundamentally re-imaging what mental health services could look like.

Mental health services can be part of broader social changes that usher in greater equity, freedom and justice, as well as greater social inclusion for marginalized groups (Cowan et al., 2011). There have been commitments for just such changes at times, such as with the New Labour government of the UK in the early oughts.

Radical reformation has been addressed in some ways throughout this thesis. The vision of radical reformation that is the natural consequence of this discursive analysis is one in which service users are given broader ranges of treatment opportunities and real choices within those opportunities. It means providing meaningful support, even when the person is legally deemed capable of personal decisions. In fact, it is a vision in which self determination is only possible in an environment in which the individual is

supported in the choices they make. This means greater access to social inclusion, employment when desired, financial and housing stability; that is, a set of services that actively addresses marginality across a broad range of factors.

7.4 Key Points

In this Chapter, I revisited the concept of exploitation. An expanded and contextualized definition of exploitation was provided. From this, exploitation was examined using Bacchi's WPR approach, which provided a framework for the issues that would affect any policy interventions related to exploitation. From there, with the understanding that the larger issues uncovered in this thesis are systematic, some potential policy actions directly related to the issue of exploitation of people with mental health problems were proposed and analysed in context.

Chapter 8 Conclusions

8.1 Research Aims and Objectives

The initial aims of this study were to 1) describe and understand the social-historical forces that influence how people with mental health problems are vulnerable to abuse and exploitation, and 2) understand and describe the resources available to mental health service providers, and how the service providers may – or may not - utilize these resources effectively. These aims were revised during the process of data collection and the uncovering of evidence. The first stage of data collection and analysis (documentary analysis and tracing of discourses) revealed troubling gaps and inconsistencies between the major discourses that were related to the topic of exploitation, which required the study parameters to be widened: Thus, the revised aim of the study became to examine Scotland's current Mental Health Strategy and to uncover broader insights into mental health policy and practice in Scotland. In this stage, the secondary aim was to examine potential problems and propose potential solutions at a strategic level. Finally, the study aimed to revisit the question of exploitation as a case study, through the lens of lessons learned during the analysis of the archive. This project was designed with the intention of providing policy-level guidance to health service providers.

8.1.1 Significance of Research

The project provided valuable insights towards answering the research questions, albeit in some unexpected ways. Exploitation, specifically that of persons with mental health problems, exists in a discursively created space in which there are conflicting expectations of people with mental health problems. As discussed in Chapters 4, 5 and 6, people with mental health problems, while seen as vulnerable, are also dogged by perceptions of dangerousness, moral inadequacy, and even seen to be burdensome to society. The most negative aspects of their defined identity means others see many people with mental health problems as undeserving of the types of assistance that others receive. This, this thesis argues, can underlie a sense

that people who have mental health problems – especially severe and enduring mental illness – may be more 'deserving' of poor treatment, abuse and exploitation (in a similar vein to how people who use drugs, are homeless, etc, are perceived as being 'more deserving' of ill treatment). The depth and effects of these perceptions among the public will be a fruitful avenue of future studies.

The role of service providers is clarified through this research. Through the analysis it became clear that both meta-discourses are prevalent throughout the documentation. That is, both the "Harms-Paternalist" discourses, which encourage seeing people with mental health problems as potentially dangerous, burdensome, and so on exist in services and thus inevitably will influence professional practice. Further, "Rights-Autonomy" discourses exist as well. These discourses currently seem to encourage professionals to allow people with mental health problems the dignity to make their own choices, even those choices that seem like they may be harmful to them (namely, they have the "right to make poor decisions" or engage in harmful relationships). This can encompass noncriminal exploitation. While this currently opens up a 'gap' in which people with mental health problems can be subject to noncriminal exploitation while receiving little material support, it can also prove to encourage a more supportive environment for the service user. Thus the moral components of the research question is also somewhat addressed "what *ought* service providers do in these situations?/What can they do to disrupt…?" A supportive environment is beneficial, but more structure (as discussed in the recommendations, Chapter 7) to that support is encouraged and necessary to address the real harms that can be done to marginalized persons. Further, as discussed in Chapters 4 and 5, there is a strong component of power relationships embedded in services. Currently, the power dynamic is very strongly situated with professional service providers. Disruption of this power dynamic in specific ways is recommended (as in Chapter 7).

The answers to the research problem help to clarify the lived experiences and marginalized position of people who live with mental ill health in Scotland. Further, it clarifies the role played by mental health services and service providers in advancing marginalizing discourses even as they attempt to mitigate them. Understanding this problem – in detail - is the vital first step in making the necessary changes to actually implement the rights based mental health services in Scotland. This research will contribute to the understanding of marginalization of people with mental health problems.

Understanding the nuances of exploitation – and how it exists at a confluence of concepts of vulnerability and autonomy - provides an understanding the position of people with mental health problems within society, and reveals flaws in our institutional approaches to mental health services.

That is, cleverly designed programming aimed at disrupting perceptions of vulnerability will target the dehumanization of people with mental health problems, making exploitation of them less likely and will also make it more likely that others will intervene or provide assistance as needed. Implementation of programs designed to mitigate the factors that increase the exploited persons dependence on exploitative relationships is also potentially a fruitful avenue to explore.

8.1.2 Key Findings

There are a number of key findings in this research, toward answering the research questions. To briefly summarize:

Chapter 4: The analysis of the textual archive found the presence of two major macro-discourses, named the Harms-Paternalist and Rights-Autonomy discourses. Further, it was found that between these discourses are a number of discursively formed identities for people with mental health problems. These formed identities have significant implications for how service users interact with mental health services. This helps to address RQ1) How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental

health problems? as well as RQ2) How are mental health service providers represented in this relationship? It was found that there are two discourses that impact the relationship between society and people with mental health problems, which I argue enable exploitation of people with mental health problems. These discourses not only form the identities of people with mental health problems which often reinforce their marginalized status in society, but also form a gap within mental health services in which exploitation can exist.

Chapter 5: It was found through examination of the Mental Health Strategy that the discourses and discursive gap are present in the strategy. Further it is found that there is a strong emphasis on the role of professional, and little substantiation of the role of the service user in designing care or determining outcomes of treatment. As such, there is a strong power differential between service users and service providers, with the bulk of the power being held by professionals. The presence of Harms-Paternalist discourses is much stronger and better resourced than the Rights-Autonomy discourse. It is concluded that as a result of this, the Strategy fails to meet its own stated goals of providing guidance towards rights-based and person-centred mental health services.

The existence of the discourses within the foundational document of Scotland's mental health services further helps clarify the answer to RQ1) How does the relationship between society and people with mental health problems affect or allow noncriminal exploitation of people with mental health problems? And RQ2) How are mental health service providers represented in this relationship? The presence of the discourses, and perhaps more importantly, the discursive gap, can provide an explanation for how service providers can be participants in the discursively created identities of people with mental health problems.

In this Chapter, RQ4 is also addressed: Are existing policies and procedures effective in protecting the rights of people with mental health problems from exploitation? By analysis of the findings, it is argued that Scotland's mental health strategy fails to adequately address the rights of people with mental

health problems, and also fails to protect or enable the rights of people with mental health problems.

Chapter 6: In Chapter 6, RQ3 (What are the obligations – moral or otherwise - of mental service providers in addressing noncriminal exploitation of people with mental health problems?) is addressed through reference to the findings. The identities formed by the discourses that are present in the archive, and the relationship of service users and services, introduce some ethically problematic dynamics. Through examination of potential actions, it is demonstrated that service providers have been voicing concerns with the design of mental health services, and that these concerns and wishes are consistent with the Rights-Autonomy discourses.

8.1.3 Key Recommendations

Key recommendations targeting mental health services and exploitation are outlined in Chapter 7. This includes supporting the formation of advocacy groups, media outreach and awareness campaigns informed by the principles of Rights-Autonomy discourses, and clarification of obligations of service providers.

Beyond these potential actions, there are a number of ‘lessons learned’ from this research for the broader mental health service community in Scotland: It is imperative to understand the presence and impact of Harms-Paternalist discourses in the Strategy as well as in related policies and practices. It bears repeating that the key finding of this research is that making mental health services align with rights-based and person-centred care is not fully possible while commitments to paternalistic care remain embedded in recommended actions; while a fundamental understanding of people with mental health problems as dangerous to self or others is present within the strategies, policies and procedures; and while people with mental health problems are generally regarded as potentially incapable of sound decision making.

People who use services and the people who currently deliver services are generally well informed of the needs and gaps. Consultations should of course continue but must be taken seriously. A sincere engagement with more radical proposals will be needed to re-orient services away from the supremacy of professional mental health providers performing services on or to service users, and towards a service that is genuinely led by the service user and is responsive not only to individual needs and preferences. It is also required to form a service that respects human rights as non-negotiable. This will require greater resourcing. But the outcome that is allegedly being sought will not come around through half-measures and attempts to maintain the current status quo.

8.2 Contributions

As noted in Chapter 2, there are numerous and substantial gaps in the literature that this study helps to fill. First, is a gap in the understanding of exploitation as an applied concept, especially in relation to mental health problems and other marginalised identities. While there are important philosophical arguments for the nature of exploitation, these arguments have not been applied to any field beyond philosophy at a theoretical level. This research attempts to do just this. In doing so, some further ideas around the necessary conditions for exploitation were explored. The relevance of these conditions to marginalised or “vulnerable” persons are also further explored. This is an important theoretical contribution that I hope can inspire further exploration of the concept of exploitation and its relevance to other marginalized groups.

Secondly, there is a significant gap in the literature regarding the concept of exploitation and how it applies specifically to people with mental health problems. But most relevantly, there is regular reference in the literature that individuals with mental health problems are “vulnerable” to exploitation. As such, this seems to be a case in which the claim is made with little theoretical or empirical evidence directly backing the claim. As with above, this research advances a theoretical framework for how exploitation can and will apply to

people with mental health problems. However, as is discussed below, there is still work to be done in terms of gathering more empirical evidence to support the claim, and to provide further nuance to understanding this issue.

The results of this study are consistent with a large body of literature in various critical studies. In particular, the findings that power structures heavily favour professional service providers over service users is broadly present in social sciences and beyond.

The research findings can be applied to policy development at a foundational level. The insights provided by this research can inform policy makers on how to restructure Strategy and policies to better align with the values they are espousing. It can guide policy makers to be more mindful of how they are embedding paternalism into their policy and how this impedes other principles such as the prioritization of human rights and person-centred care planning.

8.2.1 Theoretical Contributions

The discovery of the discursive gap in the mental health services of Scotland policies, procedures and Strategy is the most important contribution to knowledge from this study. The framing of issues related to principles embedded in Rights-Autonomy and Harms-Paternalist is a helpful way to understand the various tensions that exist within the policy framework. Most importantly, this framework demonstrates clearly how policy in Scotland is unlikely to make substantial changes in the direction of person-centered and rights-based care under the status quo.

There is a further theoretical contribution made in a refined definition of “exploitation” that is relevant to persons with mental ill health or disorders. The understanding of exploitation, why it happens and how it should be addressed by society is significantly advanced by this thesis.

8.2.2 Methodological Contributions

A minor methodological contribution (Bergh et al., 2022) made during this study could be informative to other researchers attempting to apply critical discourse analysis to a broad range of documents that inform a single issue: As per Bergh et al., (2022) a minor methodological contribution is made where a study's methodologies might lead to a change in a subset of future studies.

When it became apparent that no single methodology would fully provide the answer to the research questions, I utilized a number of methodologies in different phases of the study, and compared the results to form a conclusion based on the broader whole. I found that the different methods used were complementary and enhanced the understanding of the discourses.

The nature of this project required a flexible approach and one that allowed for larger numbers of documents to be assessed than is typical in a discourse analysis. The specific outcomes I was searching for did not fully fit any of the methodologies available. For example, while elements of DHA were helpful for data analysis, and for providing a framework for analyzing discursive themes *across* documents while respecting the relationships between documents and the time frames in which they were active, there were elements of DHA that were too rigidly focused on the historical aspects of documents. In the case of my study, I was focused on contemporaneous impact of the documents rather than a full understanding of the historical contexts in which they arose (though of course, a section of this thesis is indeed dedicated to drawing out that very historical context).

The successful combination of various elements from CDA can be instructive to other researchers, especially to researchers who like myself are studying phenomena that exist at the intersection of a number of different fields of study, or to researchers tracking discourses and their impacts across multiple levels. The use of multiple methodologies helped to fill gaps and provide insights that the use of a single methodology would not have.

8.3 Limitations

While this study was fruitful there are a number of limitations that might affect the results. Future research should take into account these limitations.

While critical discourse analysis is inherently political and assumes researcher bias, as described in Chapter 1, it does bear repeating that this researcher has significant professional experience in the field of adult acute inpatient mental health services. As described in Chapter 3, this presents a natural biases in terms of analysing the data, despite efforts towards mitigating these.

This study was narrowly focused on the mental health policies and services of Scotland. While there are some common elements between these services and the services of other countries, there are a number of unique aspects of Scotland's mental health service that might affect the generalizability of results. Most notably is Scotland's strategy of implementing 'rights-based' and person-centered mental health services, which is not necessarily a stated intent of other services at this time. But with that said, "Rights-based and Person-Centered Mental Health Care" has been identified by leading international organizations such as the WHO and the UN as priorities. As such, this study can be highly informative for other countries or organizations who seek to implement rights-based care in mental health services.

One notable constraint that was discovered early on is the relative dearth of empirical data regarding the exploitation experienced by people with mental health problems in the literature. The small number of studies that do exist were small and qualitative. This lack of data constitutes an opportunity for future research. Increasing the quality and quantity of the available data will help justify further initiatives, and will add significant nuance to understanding the issue. This study, due to the lack of detailed data on the subject of exploitation, was restricted to providing a more theoretical model that by necessity expanded beyond the parameters of noncriminal exploitation.

8.4 Recommendations for Future Research

There are a number of future research projects that can come from this study. Primarily, as noted above, is collection of empirical data to expand and provide nuance to an issue that is poorly understood but widely acknowledged. Data could and should be collected on the experiences of people with mental health problems, as well as on the perceptions of service providers and of the public towards people with mental health problems, especially vis a vis the discursive elements identified in this study. The macro-discourses described in this study can be applied to a large array of mental health policies, in order to evaluate them for the presence of discourses an to uncover tensions that exist within individual documents and across or between bodies of policy documents.

8.5 Concluding Statements

This study was motivated by my personal professional experience working in an acute care psychiatric unit, working with persons with mental health problems, many of whom were admitted under the mental health act. This experience revealed that people with mental health problems are frequently subject to exploitation in many forms.

This study concludes that this experience occurred in a discursive gap that exists in mental health services. This discursively created gap is the inevitable result of attempts at changing mental health services by increasing the autonomy of service users, while maintaining commitments to neoliberal principles related to the harmfulness of people with mental health problems, their value to society, their power within the mental health service system, and the rights to which they are entitled.

Human rights must be given the primary space in mental health strategy and policy. The focus must be not only the right to autonomy but also the right to maximum attainable level of health and right to safety. Patriarchal commitments to discourses of the dangers posed by people with mental health problems, and to carceral interventions, must be removed. This

ultimately means a radical re-constructing of the principles on which mental health services are based, and disruption of power structures that give primacy to medical professionals and especially to police within mental health services. This shift ultimately requires an acknowledgment that certain elements of mental health services are not simply old fashioned, but that continued commitment to them *actively impedes and counters* the ability to propose actions that are protective and promoting of human rights in persons with mental health problems, and who use mental health services.

Ultimately, shifting away from paternalistic and marginalising services should be seen by all as a worthy goal of policy development. This thesis concludes that while many policy makers have good intentions, we have yet to make the meaningful changes to allow that vision to be realised.

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Appendix A: Literature Search Strategy

The literature search was undertaken mostly online. Articles, reports, strategy and policy documents were located and accessed online. Books were located online and were accessed online or physically (through library loans or purchase).

The University of Edinburgh library (via the DiscoverEd platform), websites and search engines such as Google were used to access literature databases, policy and strategy documents. The literature search was limited to English language. In some cases, dates were not limited to search for historical records. However, for the most part the literature search was limited to articles and books published after 1990.

For the literature review, mostly academic and peer reviewed documents were searched (as such, most searches were limited to 'peer reviewed' articles and 'books'. However, in some cases, Strategy and policy documents were sought. These were generally found through Google searches.

Titles, abstracts and keywords were screened for relevance. Also noted were the source of the article (namely, coming from reputable publishers). Currency of the articles were noted where relevant (noting that in certain cases, historical documents were specifically sought out). Additional searches were undertaken to ensure up-to-date information.

Articles excluded from the literature review included studies conducted in countries with little alignment with the UK system or cultural context. Also excluded were articles discussing exploitation from perspectives outside of social, psychological and mental health contexts (namely from biological, computer sciences). However I was careful not to overly limit my searches as topics from fields such as philosophy and other humanities were directly relevant to many of the concepts investigated. As such, the initial search parameters were deliberately left very broad.

In each case, searches on various topics were conducted first broadly using DiscoverEd and then Google. Following the retrieval and review of a number of articles that helped provide context for the coverage of the topic, further searches were conducted narrowly in specific databases, namely Pub Med, and at times EBSCO and CINAHL plus.

The literature review was structured around concepts and seeking multiple perspectives on those concepts. As such, multiple search strategies were used for each concept.

TABLE 1: Literature Review Search Strategy Overview

Item	Details
Databases searched	DiscoverEd (physical resources located at University of Edinburgh Library, or purchased) Google Search, Google Scholar Specific Searches in: Pub Med EBSCO CINAHL plus Google Scholar
Search Terms	See Tables 2/3 for details

Context of Search	The first stage of the formal literature review entailed defining key concepts based on the research questions and aims/objectives of the study at the time. The relevant topics were noncriminal exploitation, mental health/illness, and mental health services.

Stage 1: Exploitation

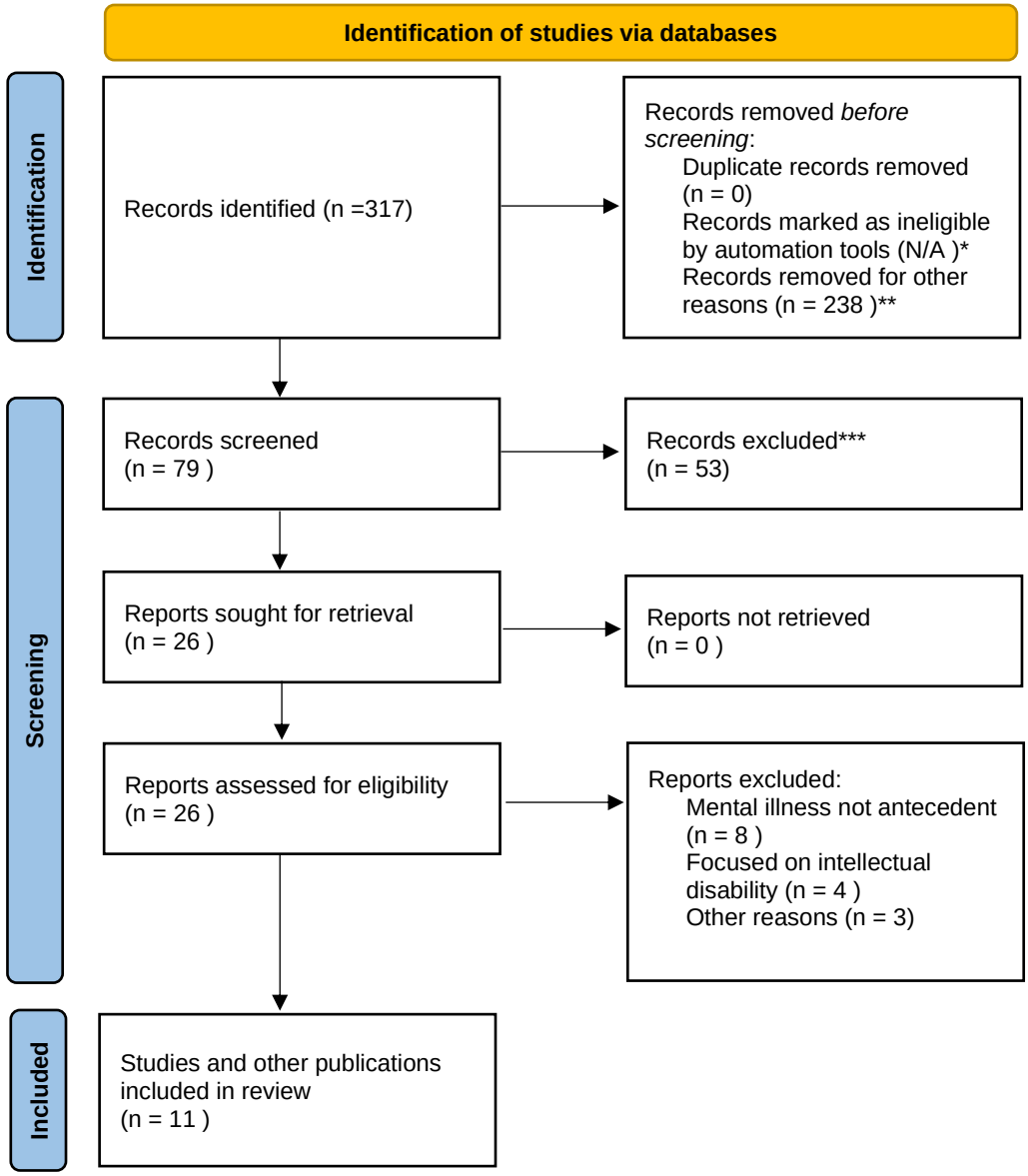
The literature review started with a comprehensive review of the literature specifically around the topics of exploitation and mental illness (as the research was originally conceived). The search terms Exploitation AND Mental Health OR Mental Illness were used, using the University of Edinburgh's online library resources accessible through DiscoverEd. The searches were restricted to English language and limited to literature from 1960 onward. This is due to the expectation that there would be some historical articles that may be of interest.

TABLE 2: Literature Review Strategy for Initial Search

Search tool	University of Edinburgh DiscoverED
Search parameters	All items/that match keywords/anywhere in record
Time period searched	1960-2020
Keywords used	"Exploitation" AND mental illness OR mental disorder (see chart below)
Filters applied	Peer Reviewed Journals/ Books

Resultant articles	260
Resultant books	57
Process	Title, Abstracts, and Keywords reviewed to assess relevance, remove duplication Results were sorted by importance, namely by numbers of citations.
Articles included	11
Books included	0

FIGURE A.1 PRISMA Flow Diagram for Initial Search



*No automated tools were used

**Articles, books and chapters excluded for lack of relevance to the topic (mental health;)

*** Records excluded for lack of relevance

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Following this search, additional alternative search terms were introduced as outlined in Table 3.

TABLE 3: Alternative keywords and phrases searched after initial search

Concepts		**Alternative keywords/phrases searched**		
AND	Exploitation	Abuse	Harm	
	Mental illness	Mental health	Madness	
	Crime	Noncriminal	Illegal	
	Health services	Mental health service	Psychiatry	Medical services
	OR			

Using these search terms, 14 additional documents were identified that help fill out the context and content of the "exploitation *and* mental illness" literature review.

Stage 2: Defining the Scope of the Literature Review

The scope of the literature review was defined by the research questions and informed by the initial literature search on the topic of "mental illness *and* exploitation". Initial concepts were mapped (see below) based on initial readings and background knowledge of the topics. Additional topics were added as necessary (listed below as emerging concepts).

It was important to the study to review not only academic literature but also 'grey literature' such as government and NGO reports and legal documents. These documents were located generally using the google search engine.

TABLE 4: Defining Key Concepts

Topic	Subtopics/researcher's notes
Exploitation	Abuse/harm #Marxism/post-marxist accounts Focused on defining exploitation in a meaningful way. Key documents were discovered and citation mining was extensively used. Key documents included Wertheimer and Sample.
Vulnerability	Individual and population Role of stigma This topic was identified as a central issue from literature on exploitation. Database searches on vulnerability and mental illness were conducted (see below)
Marginalization	Relationship with society This topic became important due to the relevance of concepts of marginality to vulnerability and mental illness.
Mental illness as a construct	Cultural psychiatry Cultural competence Different experiences; interpretations of experiences Lessons about imposing values and definitions

	This topic was identified in early stages due to interest in understanding how mental illness is constructed through social meaning and interactions. Relevant to the epistemological framework.
Power	Authority Power is a central concern when examining issues of vulnerability. Power is a central factor in the relationship between mental health service providers and users.
Social contracts	Justice This topic was identified as relevant to how mental health service provision is socially mediated and defined. How are service providers empowered by society to have the special rights to make decisions for people with diagnosed mental illness. Issues of licensing and regulation of mental health service providers was of interest.
Role of healthcare	As exploiter As intervener Laws/regulations/codes of conduct Strategies utilized for wellbeing: Direct intervention; Harm reduction?; Community building This is related to the above topics of the socially mediated role of health service providers. This is central to the research questions (especially RQ1).

Ethics	What ought the role of healthcare providers be? How ought they leverage power? How do they currently leverage power? What are the risks to the service user? (This became RQ2). Due to issues related to power and vulnerability, it was important to gain an understanding of some of the prevalent ethical issues that are in play.

Stage 3: Search Concepts

TABLE 5: Search Parameters for Key Concepts

Initial Concepts	Alternative Keywords/Phrases	Databases/Register Searched	Notes	Used
Exploitation (empirical)	Exploitation AND study AND mental illness OR mental disorder	DiscoverED EBSCOhost PubMed CINAHL plus	Numerous iterations of search terms used. Very limited number of studies found that met criteria (namely focused on people with mental illness who experienced exploitation). Excluded studies on people who	5

			were exploited who then suffered mental illness as a consequence	
Vulnerability	Vulnerability AND mental illness OR mental disorder	DiscoverED EBSCOhost PubMed CINAHL plus		42
Marginality	Power AND Marginality Social exclusion	DiscoverED PubMed		16
Mental illness as a social construct	Cultural psychiatry Transcultural psychiatry Cultural perspectives on mental health/illness	DiscoverED EBSCOhost PubMed CINAHL plus	Did not end up referencing transcultural issues per se, outside of acknowledging them. Focused on Western/UK approaches and cultural perspectives.	2
Social contracts	Social Contract Theory AND health Social contract theory AND mental health Social contract theory AND health services	DiscoverED EBSCOhost PubMed CINAHL plus	I did not end up referencing social contract theory except in passing	2

Power	Power AND Mental illness Authority	DiscoverED PubMed CINAHL plus		15
Role of healthcare		DiscoverED EBSCOhost PubMed CINAHL plus	Scottish Laws Human Rights	4
Ethics	Ethics AND mental illness OR mental health	DiscoverED PubMed CINAHL plus		13
Emerging Concepts	**Alternative keywords/phrases**	**Databases**	**Notes**	
Critical Approaches to Mental health/illness		DiscoverED	General search/ Specific searches for articles/concepts as referenced in initial literature findings (citation mining)	5
Scottish Laws	Mental health Act	Google search	Searched for specific laws/acts relevant to Scotland and mental health services, as referenced in initial literature findings	4

Human Rights		Google search	Searched for specific relevant human rights laws, treaties and conventions as mentioned in literature	5
	Human rights AND mental health	DiscoverED EBSCOhost PubMed CINAHL plus		2
Advocacy/ Activism	Advocacy AND Mental health Mental health activism	DiscoverED PubMed	This topic was added later, after data analysis was completed. Conducted largely through targeted searches and citation mining.	9
Historical, Social, Political Contexts		DiscoverEd, primarily citation mining looking up specific articles PubMed	These topics were built up after other topics were completed, largely through the process of citation mining from other literature as it arose.	n/a

Note that following these initial searches, my search strategy became much more targeted. Once the initial literature review was written, subsequent additions were made as necessary. This involved highly specific searches to fill in topic areas, add additional information, or broaden the scope of the literature search. This was completed via database searches for specific articles, and very often through “citation mining” once appropriate articles were located.