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ORIGINAL ARTICLE

Health professionals' perceptions of user involvement in a mental health centre: A critical discourse analysis

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Abstract

The objective of this study was to investigate the engagement between healthcare professionals and users of mental healthcare at the individual level in a mental health hospital. A qualitative research design with purposive sampling was adopted. Five audio-recorded focus group interviews were conducted with nurses and other health professionals at a mental health hospital in Copenhagen and were explored using Fairclough's discourse analysis framework. This study shows how users can be subject to paternalistic control despite the official aim that user involvement be an integral part of the care and treatment offered. As evidenced in discussions by health professionals, the users were involved in plans based on conditions determined by the health professionals who were predominantly focused on treating diseases and enabling the users to live a life independent of professional help. Our results can contribute to dealing with the challenges of incorporating user involvement as an ideology in mental health hospitals.

KEYWORDS

clinical-research approaches, discourse analysis, mental health hospitals, patient participation, user involvement

INTRODUCTION

Over the past decade, user involvement in mental health centres has been viewed as a milestone to be reached within psychiatric treatment in Western societies (Kang & Joung, 2020; Tambuyzer et al., 2014). According to Danish healthcare policy, user involvement is presented as a stated objective, with legal requirements for healthcare professionals to ensure that users systematically participate within their course of care and treatment, from start to finish (The Ministry of Health, 2022). That user involvement has become such a clear requirement in the healthcare system is due to user/survivor movements demanding more involvement, citizens' democratic rights, and society's tendency to pay tribute to self-care and autonomy (Tambuyzer et al., 2014). From a health professional's perspective, user involvement can lead to improved treatment processes and quality of care, and a more effective service with economic benefits (Jørgensen, 2019b). Moreover, user involvement can reduce adverse incidents as the users become the watchdogs of their own care, taking precautionary measures against flaws in a pressured healthcare system (Jørgensen et al., 2018). A mounting body of evidence highlights the advantages of engaging individuals who use mental health services, both at a systemic and individual level. It is imperative for the system to prioritise meeting the needs of these users (Jørgensen & Rendtorff, 2018; Kang & Joung, 2020; Rettke et al., 2015; Tobiano et al., 2015; Viksveen et al., 2022; Wiklund, 2021).

User involvement has become a means to ensure the goal of quality in the healthcare system and although many health professionals associate involvement with something positive, the concept arouses uncertainty among those who must carry it out (Thimm et al., 2020). Despite it being widely acknowledged that user involvement is an integral part of providing mental healthcare services, a consensus about the definition

of user involvement has not been reached (Jørgensen et al., 2021).

A variety of definitions of user involvement in mental health care have been suggested in the research literature. The Danish Knowledge Centre defines user involvement as 'a term for the user being given influence over his own course in the healthcare system based on their individual knowledge, preferences, and resources. This is done through dialogue, decisions about treatment and care and/or organisation of activities' (Louise & Lipczak, 2022, p. 18). Several researchers are sceptical about the ideal of user involvement because it shifts a large part of the responsibility for recovering from an illness onto the user, who is already affected by the illness and does not always have the energy to decide on many questions. At the same time, there is uncertainty about how health professionals understand involvement and carry it out in clinical practice with users in mental health centres (Jørgensen et al., 2023; Mik-Meyer, 2014; Rose, 2019). Despite several proposals for definitions, there is no generalised definition of user involvement. However, this can be perceived as an effort to decrease social disparities, encourage users to take care of themselves, and address the challenges faced by semi-professionals in terms of exerting influence. Alternatively, it can be viewed as an initiative to lower costs in the public system by placing greater responsibility on users for their own treatment (Petersen, Hounsgaard, et al., 2012).

Different perceptions of user involvement appear in the research, and the different meanings can be understood as linguistic social constructions. These linguistic expressions can be assumed as discourses involving different notions of what role users should play in a social community between health professionals and users who are impacted by a mental illness (Beedholm et al., 2014; Hansen, 2013; Jørgensen, 2019a; Petersen, Borg, et al., 2012; Praestegaard et al., 2015). According to Fairclough (1992), language expresses how one thinks and acts. There are only a few articles that show which discourses talk about user involvement (Jørgensen et al., 2021; Jørgensen, Praestegaard, & Holen, 2020). Based on Fairclough's (1992) discourse analytical framework, this study sought to investigate the manner in which health professionals express user involvement in interactions between healthcare professionals and users of mental health care at the individual level within a mental health hospital.

METHOD

Choosing Fairclough's (2013) approach for studying language about user involvement is advantageous due to its clarity and structured analysis. Fairclough's method simplifies complex language, aiding a clear understanding of user involvement discussions. It offers a systematic framework for language deconstruction, facilitating comprehensive study. Additionally, it enables insightful interpretations, delving into language's impact on attitudes and perceptions regarding user involvement, akin to solving a puzzle to yield coherent understanding (Beedholm et al., 2014).

A social constructivist approach was chosen since user involvement is only accessible to people through social interactions where experiences are developed and recognised. User involvement is something relative that takes place in a social context. Our cognitions are socially constructed because we recognise through linguistic concepts. Language presupposes communication between people (Wenneberg, 2010).

Discourses on user involvement originate from a multidimensional and social practice that unfolds in specific political, socio-cultural, economic, and historical circumstances (Jørgensen et al., 2002; Middleton & Uys, 2009). Accordingly, this study was designed as a critical discourse analysis and aimed to shed light on the linguistic-discursive dimension of social and cultural phenomena, as well as on the processes of change in late modernity. Involvement can be understood as something natural, but beneath the natural surface there is an obscure social influence that cannot be immediately spotted (Fairclough, 2003; Jørgensen et al., 2002; Wenneberg, 2010). We investigated how discourses are practiced in order to maintain the social world and social relations, which will always be subject to power relations (Fairclough, 1989). Discourses illustrate the language used and reflect the talk about and understanding of the world; language should not only be seen as something individual but a form of social practice (Fairclough, 1992, 2013). According to Fairclough, discourses reflect the social world and other social practices. Furthermore, discourses shape the social world just as they are developed by social practice, and the discourses are in constant development.

RECRUITMENT AND SAMPLING

We used a purposive sampling technique to include participants (Kvale, 2007) and obtained permission from the management of the mental health centre to invite participants to the project (Parahoo., 2014). We included health professionals, mainly nurses, but also others, for example, a physiotherapist, an occupational therapist, a social worker, a bachelor of psychomotor therapy and assistant nurses. The health professionals had at least 1 year of experience in the treatment and care of users with mental disorders. In total, 24 informants agreed to participate. Among the healthcare professionals, 17 assisted with treatment in an inpatient mental health centre and seven were employed in a mental health outpatient unit (Table 1).

TABLE 1 The contexts of the participants.

Focus groups	Context	Number of participants	Titles
1	An acute mental health inpatient unit	5	A bachelor of psychomotor therapy, and nurses
2	An acute mental health inpatient unit	6	A physiotherapist, a social and healthcare assistant, and nurses
3	An acute mental health inpatient unit	6	An occupational therapist, and nurses
4	Mental health outpatient unit	7	A social and healthcare assistant, and nurses
The number of participants		24	

TABLE 2 The Fairclough-inspired analytical main question (Fairclough, 1992, 2008).

Text analysis	Vocabulary		How are meanings worded? What interpretative perspective underlies this wording? What are the 'key words'?
	Grammar	Interactional control	To what extent is control negotiated as a joint accomplishment of participants, and to what extent is it asymmetrically exercised by one participant?
		Transitivity	What process types are most used, and what factors may account for this? Is grammatical metaphor a significant feature? Are passive clauses or nominalizations frequent and, if so, what functions do they serve?
		Modality	What sort of modalities are most frequent? Are the modalities predominately subjective or objective? What modality features are most used?
Discursive practice	Text production	Manifest intertextuality	What other texts are drawn upon in the constitution of the texts, and how?
	Text distribution	Intertextual chains	What sorts of transformation does this (type of) discourse sample undergo; is it stable, shifting, or contested?
	Text consumption	Coherence	What are the interpretative implications of the intertextual properties of the texts?
Social practice	What is the nature of the social practice of which the discourse practice is a part – why is the discourse practice as it is?		

FOCUS GROUPS INTERVIEWS – SAMPLE

The first author sent information about the study and elaborated on it at meetings with management and potential participants for the study. The first author informed the participants about the purpose of the project and their legal and ethical rights. The first author came to an agreement with the manager of the mental health centre in Copenhagen. Four wards from the mental health centre, with several healthcare professionals, gave informed consent to participate in the study.

The empirical data were collected through open interviews in each of the four focus groups to uncover the informants' perspectives in depth (Morgan, 2012, 2014). We carried out focus group interviews to achieve interaction between the participants and, through the role of facilitators, we encouraged discussions rather than having an interviewer ask questions. Through a dynamic dialogue, the participants developed insight into their experiences with user involvement. We developed an interview guide with themes to open up a discussion about how the participants reflected on user involvement. We focused on follow-up questions to achieve richness and depth (Table 2). The four focus group interviews were planned with health professionals from a mental health hospital: three interviews with health professionals from an inpatient unit and one with professionals from an outpatient unit. The mental health centre was part of a large hospital in Copenhagen with more than 20 inpatient and outpatient wards.

The focus group interviews lasted about an hour and were conducted in their unit according to the participants' wishes.

The first, second, and third author conducted the interviews. The first author was a moderator for the three focus group interviews, and the second an author for one. Two researchers asked questions while the third assisted with supplementary questions and validating the content at the end of the discussions. The interviews were transcribed by the second and third co-author.

The research group consisted of five professionals. Two researchers were trained psychiatric nurses with PhDs, one was a teacher with personal experience in mental healthcare, and two were registered nurses (RNs) who took on the role of research assistants.

DATA ANALYSIS

Fairclough refers to language use in a social practice, and discourse is understood as the kind of language used within a specific context and refers to a way of speaking that gives a sense of meaning from a particular perspective (Jørgensen et al., 2002). Fairclough constructed a useful framework for his analyses of discourses as social practice. According to Fairclough, discourse is not only seen as constitutive but also constituted, which means that discourse is in a dialectical relationship with other social dimensions. In social practice, there will be a constant development of discourses, knowledge, identities, social relations, and power relations, and the social practice will also be influenced by other social practices (Fairclough, 1989, 1992, 1995, 2013). Fairclough's critical discourse approach is characterised by its purpose of revealing the role of discursive practice in the maintenance of the social world, including those social relations that involve unequal relations of power. He sees that power can suppress social relations and, with the theory, he tries to shed light on power relations and thus influence social practice in a more egalitarian direction (Fairclough, 1995, 2003, 2013).

Fairclough constructed a useful three-dimensional model as an analytical framework for empirical research on communication and society, and all three dimensions should be covered in the analysis of a communicative event. The three analytics dimensions are (1) the linguistic features of the text, (2) the processes relating to the production and consumption of the text (discursive practice), and (3) the wider social practice (Fairclough, 2003, 2013; Jørgensen et al., 2002).

Text analysis looks at the formal aspects of language, such as vocabulary, grammar, syntax, and sentence structure, to understand how different types of discourse and genres are created. There are various tools used for text analysis, including focusing on key words and their meanings, examining how grammar is used to control interactions between speakers and set conversational agendas, analysing the use of metaphors and active/passive clauses, and looking at the degree of affinity the speaker has with their statements. In the research group, we carefully read each document multiple times to understand how user involvement in mental health care was expressed through the text. We conducted a detailed analysis of the texts, scrutinising them line by line and word by word. Initially, our emphasis was on examining and discussing the vocabulary used to depict patient participation specifically, the choice of words and phrasing until a collective understanding was achieved. Additionally, we delved into the main analytical questions outlined by Fairclough concerning grammar, interactional control, transitivity, and modality, and engaging in focused discussion and analysis.

In the realm of discourse analysis, the focus shifts to understanding how texts are created and interpreted, which involves their intertextual connections, the sources they draw upon, and the changes in discourse. This also includes exploring how texts are distributed and consumed, considering shifts in discourse and coherence. Our approach, influenced by Fairclough's framework, centred on text production, exploring 'interdiscursivity' and 'manifest intertextuality.' We delved into how texts are distributed, examining 'intertextual chains', and assessed how they are consumed by evaluating 'coherence' (Fairclough, 1992). We pursued a collaborative exploration of interview transcripts, integrating the insights gained from our textual analysis.

For example, our scrutiny of the text corpus revealed consistent use of terms such as 'psychotic spectrum', 'non-psychotic spectrum', 'legal measures', 'anxiety', 'self-esteem', 'body groups', 'recovery mentors', 'low-key words', 'alliance visits', 'FACT', 'package course for PTSD', and expressions that strongly communicate clear directives and normative expectations in discussions regarding user involvement. Our grammatical analysis unravelled a formal, linear, cause-and-effect logic concerning user engagement and a hierarchical positioning of professionals in mental healthcare. Consequently, we reached a collective realisation that the interview text predominantly reflects discourses rooted in a paternalistic approach that heavily relies on the perspectives and terminologies defined by healthcare professionals.

The final level of analysis is the social practice, to organise and systematise the discourse analysis, NVivo software was used (Nvivo, 2017). At this analytical level, the objective was to outline the features of the larger social activity that includes discourse practices. This comprehension forms the basis for elucidating the particular aspects of discourse practices. We participated in conversations concerning the analysis results of texts and discourse practices. In these discussions, we interpreted and investigated the societal and dominant relationships, frameworks, and discourse tendencies, as well as the ideological and political effects of these discourses. This procedure culminated in our core understanding of the social activity related to user engagement in mental healthcare (Fairclough, 2008).

ETHICAL CONSIDERATIONS

This study was conducted in adherence to the ethics of scientific work. The study was approved by Aarhus University's Denmark Research Ethics Committee (Institutional Review Board) Journal no: 2021-0304308 and Approval number: 2021-106 and was carried out according to the Helsinki Declaration (World Medical Association, 2013) and Danish law (The Ministry of Health, 2014); no formal permit from a biomedical ethics committee was required, as the purpose of the research was not to influence the informants, physically or psychologically. The participants were informed about the

project, and they gave their informed consent in writing and verbally to participate. All the invited participants wanted to participate, and no one withdrew later.

FINDINGS

We present the findings from the three-dimensional analysis following Fairclough's (2013) framework of analysis. The text occasionally illustrates the development of the discourses found, reflecting the participants' perceptions of user involvement in a mental health centre (Jørgensen et al., 2002).

THE VOCABULARY OF THE TEXTS

User involvement is often perceived as a paternalistic practice when it is articulated solely on the terms of health professionals. It seems that health professionals extend invitations to users to be involved in the treatment process, but only in ways that align with the professionals' preferences for organising the treatment. For instance, they might say, 'we involve users in our decisions', 'we incorporate their feedback into our plans', or 'we survey their satisfaction with the treatment'. This approach was evident across all the focus group interviews, where involvement was solely based on what the health professionals were willing to offer. Involvement appeared to emerge from the professionals' own understanding and organisational structures.

> Our policy requires that we involve the user in the development of their treatment plan.
>
> (Nurse)

> We actively seek their input and take their preferences into consideration when creating the plan.
>
> (Nurse)

> We value their feedback and regularly inquire about their experience during their hospitalization, their opinion of our activities, and their satisfaction with their treatment.
>
> (Nurse)

The health professionals do not provide a clear definition of user involvement, but they do have a structure for how involvement can occur. The use of certain keywords highlights a power imbalance between the professionals and the users. Some of the keywords include: users, psychotic spectrum, non-psychotic spectrum, legal measures, anxiety, self-esteem, body groups, recovery mentors, low-key words, alliance visit, FACT, package course for PTSD, many disqualify themselves for the package courses, OPUS, and ready for change. These words create an institutional language that many users do not share but are expected to fit into.

GRAMMAR

The following three analytical aspects provide insight into how texts treat events and social relations and, in turn, construct versions of reality, social identities, and social relations (Fairclough, 2013; Jørgensen et al., 2002).

Interactional control

Interactional control refers to the ways in which individuals use communication to influence the behaviour of others and shape the outcomes of social interactions. In the context of the statement provided, it seems that there was a positive and constructive atmosphere in which the health professionals were able to engage in discussion and exchange ideas freely without any individual participant exerting control over the interaction (Fairclough, 2013; Jørgensen et al., 2002).

Transitivity

Grammatical metaphor does not appear to be a significant feature in this text, as there are no examples of complex or abstract concepts being expressed through more concrete language. There are a few examples of passive clauses and nominalisations, but they are not particularly frequent. In general, the language used in the text is relatively simple and straightforward, with a focus on clear communication of ideas and experiences. The function of passive clauses and nominalisations is mainly to convey information about actions and events in a neutral or objective way, without necessarily specifying who or what is responsible for them. This can be useful in situations where there is a need to be tactful or diplomatic, or where the focus is on the action itself rather than the agent carrying it out.

MODALITY

In the analysed text, there is a mix of subjective and objective modalities. The use of the first-person pronoun 'I' indicates a subjective perspective, and expressions such as 'I think' and 'it is difficult for me' also suggest a subjective viewpoint. However, there are also objective modalities such as 'there has been more focus on' and 'we speak based on'. Regarding modality features, some of the most used in the text are modal verbs such as 'can' and 'shall/should', which express possibility and obligation, respectively. The expression 'I think'

is also a frequent modality feature that expresses the speaker's opinion or viewpoint. Additionally, there are adverbs such as 'necessarily' and 'completely', which modify the degree of certainty of the statement. Involvement is determined by others and has become a mandatory task.

> After all, there are also some impact points in the structure where you must involve the user. Where it is described that you must make a patient plan together with them, you must make treatment plans together with them.
>
> (Nurse)

Throughout the text, modal verbs such as 'must' and 'must make' are often used, which indicates obligation and necessity in the treatment and care. These modal verbs suggest that certain actions are required or expected to be taken. The overall emphasis of the text is on the importance of involving users in the planning and treatment processes, and there is a strong emphasis on the necessity of doing so.

The text presents a range of possibilities and constraints related to the concept of involvement. The use of modal verbs and adjectives helps to convey the level of certainty or possibility of the statements made. The text constructs involvement as a complex and dynamic concept that can be understood through the experiences and examples provided by healthcare professionals. The use of the modal verb 'can' implies that this understanding is not universal but dependent on the individual's perspective. Moreover, the text highlights the challenges of involving users with serious mental illness. The modal verb 'may' suggests that not all users will be in this situation, and the use of the adjective 'greater' implies that the challenge is more significant. The text also acknowledges the difficulty in involving users with more resources, with the modal verb 'can' implying that it is not always straightforward. Overall, the text presents a nuanced view of involvement, acknowledging both its potential and its challenges, and highlighting the importance of considering different perspectives and contexts. Additionally, the text highlights the importance of involving users in the planning and treatment processes, and the necessity of doing so. Modal verbs such as 'must' and 'should' indicate obligation and necessity, while the use of modal verbs such as 'can' and 'may' suggests that involvement is not universal and is dependent on the individual's perspective and context.

DISCOURSE PRACTICE

In general, the authors of these documents play a direct role in shaping user involvement in mental health centres, and which discourses it speaks to. The text contains several discourses related to user involvement in mental health care. One discourse is that user involvement is often perceived as a paternalistic practice that is solely based on the terms of health professionals. Another discourse is that the language used in mental health care can create a power imbalance between health professionals and users. The text presents a nuanced view of involvement, acknowledging both its potential and its challenges (Table 3).

The text was produced by health professionals, mainly nurses, and its intertextuality was analysed across four focus group interviews. There were no significant differences across inpatient and outpatient settings regarding the question of understanding and execution of user involvement. The discourse remained stable, with no significant intertextuality differences between inpatient and outpatient wards, but some health professionals used linguistic expressions that revealed different levels of affinity with user involvement.

The concept of text consumption coherence refers to how readers or listeners make sense of a text by drawing on their prior knowledge and experiences. The intertextual properties of a text are central to its coherence and meaning, as they allow readers to connect it to other texts and discourses, and to understand its social and ideological implications. In the case of the health professionals' text, it is noted that they mainly refer to their own experiences and less to other references like research and clinical guidelines. The discourse practice led to three discourses that show opposite values when talking about user involvement and how to involve them (refer to Table 3).

User involvement as a paternalistic practice

Through textual analysis of focus group interviews, it was found that a paternalistic approach is often employed in healthcare, where decisions may be made for patients without their complete involvement in the decision-making process. This can be problematic as it may reinforce the power imbalance between professionals and users, potentially infringing upon the patient's autonomy and leading to a lack of trust between users and healthcare providers. During the focus group interview, it became evident that all health professionals had pre-existing ideas about what user involvement entails. They articulated it to involve varying degrees of involvement, ranging from providing users with information to involving them in meetings related to their treatment. However, involvement was not solely an individual choice, as predefined treatment methods and expectations for user

TABLE 3 Discursive practice.

User involvement as a paternalistic practice
The powerful medical discourse about involvement
Achieving involvement through a structural treatment discourse

compliance showed that certain framework conditions in psychiatry governed involvement. These conditions impacted the extent to which a user was involved in their treatment. There were many statements that emphasised that the structure came first, which involved the use of treatment methods, evidence-based medicine, psychoeducation, and other measures that preceded the influence the user could have on their treatment.

> To be hospitalised, there are certain criteria that must be met and certain protocols that need to be followed. In your current state of mania, you may have ideas like wanting to go out dancing for an entire weekend. However, as healthcare professionals, it is our responsibility to intervene and limit certain behaviours that could have negative consequences for your health. Allowing you to act on these impulses could potentially worsen your condition, so it is essential that we prioritise your safety and well-being.
>
> (Nurse)

The text presents a clear example of paternalism, whereby the healthcare professional restricts users' autonomy for their own benefit. In this case, the healthcare professional must intervene to limit certain behaviours that could be harmful to the user's health. While this approach prioritises the user's safety and well-being, it also restricts their ability to make decisions about their own care. Although the text does not explicitly use the term 'paternalism', it does describe a situation in which healthcare professionals restrict a user's autonomy for their own benefit. This approach involves intervening to limit behaviours that could be harmful to the user's health, which is a hallmark of paternalistic healthcare practices. While the text does not use the term directly, it presents a clear example of the use of paternalism in healthcare. However, the focus on measurable outcomes, and the challenge of balancing them with the relational and caring aspects of treatment, can be seen as related to the issue of paternalism in healthcare. Paternalism involves making decisions on behalf of patients without their input or consent, and it can occur when healthcare professionals prioritise their own objectives or goals over the patient's wishes or values. In this context, the limited available space in mental health centres is affecting the ability of healthcare professionals to involve patients in their own treatment decisions. The focus on measurable outcomes, and the challenge of balancing them with the relational and caring aspects of treatment, can potentially lead to a paternalistic approach if healthcare professionals prioritise their own objectives over the patient's values or wishes. Therefore, it is important for healthcare professionals to maintain a patient-centred approach and involve patients in their treatment decisions as much as possible, while also recognising the challenges of the current healthcare system.

The powerful medical discourse about involvement

Language plays a crucial role in enabling or impeding effective communication between mental healthcare professionals and those they serve. The language used by mental healthcare professionals can either foster trust and connection or create obstacles that hinder users from fully participating in therapy. The healthcare professionals use a language that emphasises the power relationship between the professional and the user. This becomes apparent when the professionals talk about the treatment options that are offered to the users, and the user is the recipient of these pre-defined options. The user must fit into the range of options offered by the mental health centre.

> The language we employ holds the power to either establish trust and facilitate engagement or establish barriers that hinder involvement in therapy. The manner in which we discuss users often underscores a power imbalance, where users feel compelled to fit into predetermined processing pathways resembling medical approaches. This influence of medical language shapes our expression of involvement. Prioritising the user's viewpoint can foster a more respectful and encouraging environment, fostering acknowledgment and enhancing their mental health journey.
>
> (Nurse)

Involvement is subject to the possibility for the user to freely define their individual needs. The language used in the context of mental health care is shaped by the emphasis on medical diagnosis and treatment of individuals with mental health challenges. The articulation of involvement takes place in a landscape where the user is expected to contribute to the healthcare professionals' ability to focus on this task. At the same time, the healthcare professionals try to have a holistic approach and focus on the user's resources and empowerment strengthening. This choice of words, whether healthcare professionals' talking about illnesses or users' resources, leads to different perspectives on what involvement is and how it should be carried out. Health professionals are highly inclined to use language that prioritises the person's care over their diagnosis or symptoms, which is known as person-centred discourse. Placing the user's perspective at the centre of mental health support can promote a more non-judgemental, non-stigmatising, and respectful approach. This can help users feel acknowledged and appreciated, enhancing their experience of receiving support. When users feel that they are in control of their own mental health, this can have a positive impact on their well-being.

Achieving involvement through a structural treatment discourse

The healthcare professionals constructed a structural understanding of how involvement is executed in practice. Involvement takes place through structural organisational spaces, where the user is invited to the table and can have an influence on their treatment. Organisational meeting activities provide a framework for systematic involvement in practice. Examples of such activities include treatment planning meetings, patient planning meetings, improvement meetings, evaluation meetings, network meetings, morning meetings, and conferences. Additionally, treatment methods provide a framework for incorporating users' desires and needs. User feedback on treatment offerings is recognised as an important factor in developing these offerings. However, involvement is often reduced to contributing to the professionals' perspectives, rather than a more open evaluation of treatment overall.

> As a nurse, I believe that we prioritise engaging our users as much as possible by actively seeking their opinions and feedback on their hospital experience. We are particularly interested in hearing about their thoughts on being admitted, our activity offerings, and the treatment they receive. Our goal is to encourage users to describe their experiences in as much detail as possible.
>
> (Nurse)

The discourse text discusses two different ideas: patient-centred care in the mental health sector and the use of organisational structures as a platform for involving users in mental health centres. The first idea is briefly presented in the cited text, which demonstrates a commitment to patient-centred care and a willingness to listen to user feedback. This approach can build trust between health professionals and users, increase satisfaction, and lead to better health outcomes. The second idea is introduced and discussed in more detail. In this discourse, utilising organisational structures and spaces can promote user involvement and contribute to the decision-making processes of the organisation. However, health professionals also acknowledged that this approach may not be effective in all organisational contexts, and factors such as the size and culture of the mental health sector can impact its effectiveness. Overall, the discourse text discusses two distinct ideas and highlights potential benefits and limitations of each approach. The health professionals provided some insights into how these approaches can be beneficial, but also acknowledged that careful consideration should be given to the specific context in which they are being implemented.

Social practice

According to Fairclough's (2013) critical discourse analysis framework, the given text presents multiple discourses related to user involvement in mental health care. These discourses are constructed and shaped by the language used by healthcare professionals, mainly nurses, and are influenced by broader social and ideological factors. The analysis of the text's intertextuality across four focus group interviews highlights the stability of the dominant discourse on user involvement in mental health care, which emphasises the importance of involving users in the planning and treatment processes. However, the study also reveals differences in the level of affinity and modality that healthcare professionals use in relation to user involvement. The text reflects the tension between the need for measurable outcomes and the relational and caring aspects of mental health care. This tension can lead to a paternalistic approach to mental health care, where healthcare professionals prioritise their own objectives over the patient's values or wishes. The language used by healthcare professionals can also create a power imbalance between them and users, which can hinder effective communication and prevent users from fully engaging in the therapeutic process. Fairclough's framework emphasises the importance of understanding how language is used to construct social practices and reinforce power relations. In the context of mental health care, it is crucial for healthcare professionals to maintain a patient-centred approach and involve patients in their treatment decisions as much as possible. This requires healthcare professionals to be aware of the power dynamics inherent in their language use and to make conscious efforts to create an environment where users feel empowered to participate in their care. Additionally, the broader social and ideological factors that shape mental health care must also be addressed to create a more equitable and user-centred system.

DISCUSSION

The passage demonstrates how discussions concerning the interaction between healthcare professionals and mental healthcare users at the individual level within a mental health hospital evolve through focus group interviews, applying Fairclough's discourse theory. One of these discussions revolves around user involvement seen as a paternalistic practice, where healthcare professionals make decisions for patients without their full engagement in the decision-making process. This reinforces the power difference between professionals and users, potentially undermining the patient's independence and causing a lack of trust between users and healthcare providers. The text stresses the importance of upholding a patient-centred approach and involving patients as much

as possible in their treatment decisions to tackle these issues. According to the Convention on the Rights of Persons with Disabilities (CRPD), individuals with disabilities are entitled to legal capacity on par with others. States are obligated to honour, safeguard, and fulfil the right of all individuals with disabilities to fair treatment under the law. The CRPD promotes replacing substitute decision-making with supported decision-making that respects the self-rule, will, and choices of individuals. Assistance in decision-making should be accessible to all, aligned with the person's desires and preferences, and protective measures should guard against undue influence. The CRPD highlights that the right to legal capacity starts immediately upon ratification and should be progressively implemented, emphasising engagement and involvement of individuals with disabilities and their associations (Committee on the Rights of Persons with Disabilities Eleventh session, 2014).

Another discourse identified in the text is the powerful medical discourse about involvement. Healthcare professionals use language that emphasises the power relationship between the professional and the user, with the user being the recipient of pre-defined treatment options. This can create barriers that prevent users from fully engaging in the therapeutic process. The text demonstrates how language plays a crucial role in shaping communication between mental healthcare professionals and their users. Overall, the text presents a nuanced view of user involvement in mental health care and recognises the challenges presented by the current healthcare system. It highlights the importance of involving users in the planning and treatment processes to ensure a patient-centred approach. The text also emphasises the need for healthcare professionals to be mindful of their language and communication style so as to promote effective engagement with their users.

User involvement is subject to the possibilities that a dominant understanding of knowledge and traditional paternalistic control allow. The healthcare professionals' desire to involve users in the planning and treatment process arises from both their own interests and the fact that it is defined as a mandatory structural task. Recent research also shows this dilemma between control discourses and care discourses, where the care discourses collide with medical evidence and efficiency, and economic discourses that rank highest as decision-making bases in the healthcare system. Furthermore, recent research also problematises the aspect that involvement is subjected to a neoliberal discourse, where the responsibility for illness and recovery primarily rests on the users' shoulders (Boas & Gans-Morse, 2009; Joergensen & Praestegaard, 2018; Jørgensen, 2019b).

The discourses deconstructed in this project reveal that the notion of treatment in mental health care is constructed as an offer that the user is expected to actively participate in, based on the decisions made by healthcare professionals. In this construct, the user is transformed into a consumer of a healthcare system that has the task of diagnosing and treating to promote the user's independence, self-sufficiency, and active citizenship. The methods employed to achieve this end include medicine, education, group therapy, and social meeting forums, which together define the framework for what constitutes user involvement. This discourse creates an expectation that the user, as a consumer, will be motivated to participate on the terms established by healthcare professionals. However, this expectation ignores the fact that user involvement can also occur in individual relationships that are not subject to institutional rules and the prevailing view of medical knowledge that forms the basis of treatment. As such, there is a need to acknowledge and address the potential limitations of institutionalised approaches to user involvement in mental health care. User involvement has many definitions, such as shared decision-making, patient-centred care, and patient feedback, and all have the common goal of involving users in their own healthcare, either through seeking their input and feedback or through actively engaging them in decision-making. They recognise the importance of users' perspectives, experiences, and preferences in the delivery of health care and aim to empower patients to take an active role in their own care. Additionally, all these methods can contribute to improving the quality of care, patient satisfaction, and health outcomes and have already been discussed for decades (Charles et al., 1999). However, recent research shows that new public management, medical evidence, efficiency, and quality assurance constitute a discursive direction that surpasses a patient-centred care discourse with a user perspective at the centre (Jørgensen & Rendtorff, 2017). Instead, it shows that new public management, medical evidence, efficiency, and quality assurance constitute a discursive direction that surpasses a patient-centred care discourse with user perspectives at the centre (Abayneh et al., 2022; Charles et al., 1999; Clavel & Pomey, 2022; Marinkovic et al., 2022; Viksveen et al., 2022).

Our result is essential to staying on the cutting edge of mental health care. By understanding the different discourses that shape user involvement, healthcare professionals can adopt more patient-centred approaches that lead to better outcomes for users. The research also adds to the growing body of literature on the importance of language in mental health care, underscoring the need for healthcare providers to be aware of the language they use and how it can impact user engagement (Jørgensen, Dahl, & Frederiksen, 2020; Mik-Meyer & Villadsen, 2007). Overall, the text provides valuable insights into the complex and multifaceted nature of user involvement in mental health care. Its findings have important implications for healthcare providers and underscore the importance of maintaining a patient-centred approach in mental health care. The text's use of Fairclough's discourse theory adds to the robustness of the research and provides a solid theoretical framework for further exploration of this important topic.

CONCLUSION

In conclusion, the text explores various discourses related to user involvement in mental health care. It identifies three key discourses: user involvement as a paternalistic practice, the powerful medical discourse about involvement, and achieving involvement through a structural treatment discourse. The text highlights the challenges and tensions that arise in user involvement, such as the power imbalance between professionals and users, the impact of language on communication and engagement, and the structural constraints within the healthcare system. The findings emphasise the need for a patient-centred approach that prioritises user autonomy, acknowledges the power dynamics in healthcare interactions, and creates opportunities for meaningful user participation. By understanding and addressing these discourses, healthcare professionals can enhance the quality of care and improve outcomes for users. The text contributes to the existing literature on user involvement and highlights the importance of language and social practices in shaping mental health care. Overall, it provides valuable insights for healthcare providers and advocates for a more equitable and user-centred approach in mental health care.

RELEVANCE FOR CLINICAL PRACTICE

The research findings shed light on the complexities of user involvement in mental health care. They emphasise the importance of adopting a patient-centred approach that acknowledges power dynamics and structural constraints within the healthcare system. Healthcare professionals can benefit from understanding these research insights, striving to prioritise user autonomy, enhance communication, and create opportunities for meaningful user participation. Embracing more equitable and user-centred practices has the potential to enhance the quality of care and improve patient outcomes in the realm of mental health care.

LIMITATIONS

A small sample size and a focus on only health professionals may limit generalisability and validity. As it was limited to one analysis framework (Fairclough's), other frameworks could provide different insights. It does not consider cultural and societal factors, which may impact user involvement in mental health care differently across contexts.

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CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

The caregivers were included and gave their informed consent to participate after receiving oral and written information about the purpose of the project and the legal and ethical rules for participation. We adhered closely to the ethics of scientific work. The study was accepted by Aarhus University's Denmark Research Ethics Committee (Institutional Review Board) Journal no: 2021-0304308 and approval number: 2021-106 and was carried out according to the Helsinki Declaration (World Medical Association, 2013) and Danish law (The Ministry of Health, 2014); no formal permit from a biomedical ethics committee was required, as the purpose of the research was not to influence the informants, physically or psychologically.

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