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User involvement in the construction of a mental health charter: an exercise in communicative rationality?

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Abstract

Background This paper uses Jürgen Habermas's Theory of Communicative Action as a lens through which to examine the development of a local mental health charter.

Objective To assess whether the Charter represents the product of a communicatively rational process.

Research design and setting The paper is based on an analysis of the text of the Charter, and on documentation relating to its development, including notes of discussion groups used to identify its themes.

Findings An analysis of the notes of the discussion groups against the text of the Charter shows that the Charter's themes are based broadly on the views generated in the discussion groups. However, they also draw on norms derived from wider discourses not reflected in the discussion groups, and exclude other specific local issues. The strength of feeling expressed in the discussion groups is also toned down in the language of the Charter.

Discussion The development of the Charter was based on a participatory process that can be said to have contained elements of both communicative and strategic rationality. The strategic rationality involved in translating service users' views into language that would be acceptable to those working in the system can be seen as necessary for the Charter to succeed in bringing about change. In drawing also on communicatively generated norms from the wider public sphere the Charter can be seen as reflecting a form of generalized communicative rationality.

Conclusion The Charter represents a 'sluice' by which communicative rationality is drawn into the mental health system.

Introduction

The idea of creating a charter for mental health in the UK is one that can be traced to the 'Citizen's Charter'[1] and more specifically to the 'Patient's Charter',[2] introduced in the early 1990s by John Major's Conservative government. More widely, 'charterism' can be seen as part of the new public management agenda that has dominated welfare state reform across the

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world,[3] with charter programmes modelled on those developed in the UK being introduced in many countries.[4–7] The UK Citizen's Charter programme can be seen as epitomizing the consumerist reforms of the 1980s and 1990s, explicitly foregrounding consumer rights and choice.[8] Although the Patient's Charter contained no enforceable rights or standards, through its rhetoric it represented a shift in power away from providers to 'consumers'. However, as Drewry argues, charters have a 'chameleon-like' quality, enabling them to be embraced not only by New Right individualists but also by New Left collectivists, with their emphasis on making public services more participatory and responsive.[3] Thus the Citizen's Charter was repackaged and relaunched by Tony Blair's Labour administration before being absorbed into their 'modernization' of public services.[3] Although the Citizen's Charter initiative, and with it the Patient's Charter, has now disappeared, the practice of 'charterism' now seems to be firmly embedded within local health service delivery, with charters for various local services such as primary care practices continuing to appear.

This paper looks at a local mental health charter in one UK city, which was developed and implemented by a forum of service users and representatives of mental health agencies. Although originally published in 1998, the Charter still exists, setting out a series of principles governing the delivery of mental health services. Having emerged at a time of political transition in the UK, chameleon-like, it can be seen to reflect various ideological influences. On the one hand it can be seen as a managerially driven exercise aimed at challenging the power base of service providers, using the discourse of consumerism as the vehicle to do this. However, it was developed out of a genuinely participatory process, using the 'stakeholder' discourse that was very much part of the language of New Labour.

In his theory of communicative action[9,10] Jürgen Habermas provides us with a theoretical framework which can be used to examine user involvement initiatives such as the Mental Health Charter. In focusing our attention on the discursive processes adopted in such initiatives Habermas enables us to assess the extent to which they are genuinely participatory. In theoretical terms, that is whether they are based upon communicative rationality involving all participants in a process of reaching mutual understanding, or upon strategic rationality in which the communicative process is distorted by the use of power. It is the contention of this paper that the Mental Health Charter has the potential to introduce a degree of communicative rationality into the local mental health system. In the analysis of the development of the Charter that follows I will explore more fully what this claim for the Charter means, and will consider whether or not its potential for communicative rationality is realized.

The research

This paper is based on a study of a local mental health forum undertaken between 1998 and 2002 which involved interviews, observation and analysis of documentary data. The forum itself is an independent voluntary organization that was set up in the mid-1990s to provide a mechanism for involving service users and service user organizations in the development of local mental health policy, alongside representatives of the main statutory and voluntary sector mental health agencies.[1,11] The Mental Health Charter was developed by the forum in 1998 as a mechanism for improving standards in mental health services. All local mental health agencies are expected to sign up to it.

The data drawn upon in this paper consist of the text of the Mental Health Charter itself, along with documentation relating to its development, including notes of consultation days. Data were analysed thematically using themes identified in the Charter.

The post-hoc analysis of documentary data relating to the Charter's development on which this paper is based gives rise to some limitations which need to be acknowledged. First, it is not

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[1] I have described the forum in more detail elsewhere.

possible to identify the input of individual participants in the whole process, including members of the forum itself and participants in the consultation days. It is therefore not possible to determine to what extent the data reflect the input of individuals representing the views and interests of service user groups or organizations and those present as individuals, not as representatives. A second limitation of the paper is its reliance solely on documentary data in place of directly observed and recorded interaction. At the heart of Habermas's theory is a concern with face to face communication. This paper seeks to assess the communicative quality of the outputs from a discursive process without evidence of the face to face communication from which those outputs were derived. This was unavoidable as the research took place after the Charter was constructed. Ideally, observation and analysis would have been carried out of actual discourse that took place during the consultation days and the meetings in which the text of the Charter was agreed. However, through the comparative analysis of two sets of discursive outputs (notes from consultation days and the Charter itself) the paper is nevertheless able to offer valuable insights into the process by which the Charter was constructed.

Theoretical background

Within his overarching theory of society, Habermas[9] lays out a model of ideal, communicatively rational discourse. The goal of such discourse is to reach mutual understanding through a process of argumentation in which any speaker can make or question any statement, supporting their case with reference to objectively known facts about the world, social norms and subjective experience. The ultimate governing principle of such discourse is always only the force of the better argument. Crucially for Habermas this orientation to mutual understanding in discourse is innate in all of us as social, intersubjectively constituted beings. In our ordinary social relationships communicative action is a natural way of relating, drawing upon our shared lifeworlds of knowledge and beliefs about the world as well as our subjective experiences of it.

This model of ideal discourse is set against strategically rational discourse in which speakers treat each other as objects to be manipulated in pursuit of pre-defined interests. Strategic rationality thus represents discourse distorted by power whilst communicative rationality represents undistorted communication. Habermas's theory is both normative and explanatory. That is, it not only sets out a model of what communication ought to look like, but it also provides an explanation for why as human beings we are innately oriented towards this ideal. What Habermas does not do is to set out how this model of communication is intended to be applied in practice. However, his theory has been highly influential in the development of theories of deliberative democracy,[12,13] which in turn have influenced the growth of participatory forms of governance, one of the characterizing features of the UK Labour administration since 1997.

Deliberative democratic theory has been subject to critique, both at a theoretical level[14,15] and in applied fields such as user involvement in health and social care.[16-18] One of the main points of critique has been around the primacy given to rational argumentation which, as Iris Marion Young has argued, leads to the exclusion of other forms of communication from deliberation, especially greeting, storytelling and rhetoric.[14,19] These forms of communication help to get issues onto the agenda, shape arguments in ways appropriate to particular audiences and situations, and motivate people to form judgements about particular issues which go beyond simply coming to rational decisions.[19] The case for permitting other forms of communication in deliberation is borne out in practice, for instance in recent research in the UK which has looked at the work of the National Institute for Clinical Excellence Citizens Council.[17] In that study it was found that the style of debate that the Citizens Council engaged in was more focused and deliberative where the issues under discussion were concrete and particular and where members were responding to the testimony of witnesses with a clear personal investment in the issue under debate.

Although this critique represents a challenge to Habermas's theoretical approach it does not fundamentally undermine it. Rather, it requires us to acknowledge that in deliberative discourse communicative techniques such as rhetoric and storytelling will (and perhaps should) be used to strengthen the claims that are being made. Such techniques can be accepted as an essential part of deliberation, but for 'good' decision making to ensue from such deliberation those claims must still be capable of being tested against the Habermasian standards of factual correctness, their appropriateness to the situation and the sincerity of the speakers' intentions.

The categorical distinction which Habermas draws between communicative and strategic rationality is central to his whole theoretical endeavour.[2] Strategic rationality is the medium through which the systems of the administrative state must operate. Such systems have colonized the lifeworlds of those who are subject to them, both as workers and users of services. For Habermas, communicative rationality has no direct place in the systems of the administrative state. Instead he sees the prime source of communicative rationality as existing in new social movements operating in the public sphere, engaged in struggles to defend threatened lifeworlds from the colonizing interventions of the state and the economy. The only way for this communicative rationality to enter the system is through its translation into the language of the system, strategic rationality.

It might seem, then, that the only role Habermas's theory has for understanding system-led user involvement initiatives is in providing a metatheoretical explanation for their failures. However, it is my contention that Habermas also provides us with a valuable tool with which to test user involvement initiatives, drawing our attention to the points at which they depart from the communicative ideal, as well as highlighting areas of practice that begin to approach it. Furthermore, in his later work,[21] Habermas further develops his idea of how the formal institutions of the state are exposed to the influence of the communicative rationality that exists in the public sphere. He develops a spatialized notion of communicative rationality in which public opinion can be thought of as being formed of bundles of opinions emerging from specific communicative encounters that occur in everyday life. This communicatively generated opinion is then translated into administrative power via a series of sluices which connect the institutional core of the state to the organizations and groups that seek to influence it from the periphery. It is my contention that discursive projects like that represented by the Mental Health Charter discussed in this paper can be seen as sluices by which mental health services can be opened up to communicative rationality. In the rest of this paper I will examine the Charter in some detail to assess the extent to which this claim is borne out.

The development of the Charter

It is clear from the documentary material relating to the development of the mental health forum itself that the Charter was to be an important aspect of the forum's work from the outset. As the forum's annual report for 1997–1998 notes, the idea to develop a local 'users' charter' was agreed at the same 'stakeholders' conference' that formally constituted the forum. This document also notes that the stakeholders' conference agreed that the Charter would have high level support from the main statutory agencies responsible for purchasing/commissioning mental health services, and that the forum would oversee its development and

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[2] Elsewhere[20] I have critiqued the dichotomization of strategic and communicative rationality, arguing that this results from the way in which Habermas conceives of the intersubjectively constituted subject. Rather than understanding only our orientation to communicative rationality to be rooted in our innate intersubjectivity, I maintain that strategic rationality is also fundamentally intersubjective, and that consequently the categorical distinction between communicative and strategic rationality needs to be broken down.

implementation. Thus we can see from the beginning that there is powerful institutional backing for the Charter.

In January 1997 a working group of forum members – 'professionals' and service users – was set up to produce a draft charter. The group's thinking about how to develop the Charter can be seen to reflect an intuitive grasp of the importance of basing such a document on mutual understanding and consensus, but at the same time recognition of the need to instrumentalize it into achievable institutional objectives. The following extract from the notes of the working group illustrates this thinking:

> There was a discussion around what should be included in a Charter. The group felt that it should uphold existing rights and also set targets for services to aim for. It was suggested that targets should be realistic, but that sights should not be set too low. Targets should be measurable, and services should be able to demonstrate what they are doing to attain Charter standards.
>
> It is important to find out which existing rights are most commonly ignored.
>
> Wide consultation was felt to be important if the Charter was to be of real benefit. Difficulty that an interagency Charter is such a large area of work, covering diverse services. The group identified the following groups as important to consult with – day centres, day hospitals, people who have been sectioned, in-patients, people who only see their GP (primary care and MH), people who use social workers, counselling services (…).
>
> It was pointed out that workers are less likely to resist any changes that might be implied by the creation of a Charter if they are involved in development. They will also have ideas on what is good practice.
>
> The group felt that informal 'focus groups' might yield more information than formal interviews and questionnaires, but recognized that many people who don't use any services would not be likely to attend them. (Notes of Charter working group, February 1997)

The recognition of the need to base the Charter on a communicative process can be seen in the emphasis on the need for wide consultation and in the favouring of focus groups over interviews and questionnaires. There is also recognition of the need to draw front-line workers as well as service users into the debate about what should be included in the Charter. All this, I suggest, reflects an intuitive grasp of the Habermasian principle that 'better' policy-making occurs when it emerges out of debate oriented to mutual understanding that involves all those affected. For in this way the policy that gets made is likely to achieve a greater level of voluntary acceptance, without the need for external enforcement. I suggest that this quite ordinary thinking about policy-making can be seen as evidence in support of Habermas's argument that the basic principles of communicative rationality are intuitively understood. The emphasis on the need for the Charter to contain 'achievable goals' can be seen as reflecting the need for communicatively generated norms entering the subsystem of the administrative state to be converted into strategic rationality.

It was decided that the consultation exercise should involve a series of six discussion groups which were held in a mixture of day centres and hospital settings across the city during autumn 1997. Each group was presented with a case study followed by a series of questions, an approach intended to stimulate discussion. Notes of these discussion groups were taken, and incorporated into the Charter. The forum's 1997–1998 annual report states that:

> A wide range of issues was covered, but there were also strong themes that were common to everyone's experiences, whatever kind of mental health service they were using. It is these themes that form the 10 categories listed in the Charter. (Forum Annual Report, 1997/98)

It is clear that the account of the Charter's development in the annual report is aimed at presenting the Charter as a document whose content is derived directly from the views expressed by service users.

I now want to move on to look at the text of the Charter itself in order to assess whether the claim that the Charter reflects the views expressed by service users can be justified substantively. And if not, does this undermine the Charter's potential for communicative rationality?

The text of the Charter

The primary method I have used to assess the extent to which the Charter reflects the views expressed by service users is a comparison between the text of the Charter and the issues raised by service users in the consultation exercise. I analysed the notes of the six service user discussion groups, using the 10 Charter headings as themes around which to organize the data. These headings are: choice; access to information; staff; welcome; listening; comfort; complaints; advocacy; safety; and access. The results of this analysis show clearly that the content of the Charter is based only partially upon the results of the consultation exercise.

In the first place there are elements of the Charter that do not reflect the views expressed by service users in the consultation exercise at all. The most instructive example of this is the statement on *Access*, which is as follows:

> Service providers should strive for equitable access to their services. They should be aware of the factors limiting access. These include acts of discrimination and fear of oppression on the grounds of sex, religion, race, culture, sexuality, disability, psychiatric labelling and popular stereotyping, as well as physical access to and geographical location of the service.

This fairly formulaic equal opportunities statement clearly does not correspond in any direct way to the comments of the discussion groups relating to this issue:

- Equal treatment for all.
- Provision of a 'women's day' means that men cannot access this particular service on Tuesdays. This was felt (by some) to be unfair, as no alternatives existed.
- More provision for childcare.
- Childcare provision for women who are mothers in hospital is inadequate and does not accommodate parental views.
- We need a mother and baby unit – system doesn't support mothers.
- More locally based services.
- Services should be nearer home.
- More provision for travel expenses, or information on bus passes. (Discussion group notes)

The Charter makes no mention of the specific issues raised in the discussion groups, but only requires services to 'be aware of the factors limiting access'. Furthermore, the concern raised about the exclusion experienced by men when the services they attend hold women-only days seems if anything to challenge the substance of the Charter's statement on access. Other aspects of discrimination referred to in the Charter are not touched upon at all by the discussion groups. This demonstrates quite clearly that the content of the Charter is not drawn entirely from the consultation exercise. This could be seen as undermining the communicative legitimacy of the document. However, the inclusion of accessibility as a fundamental principle of service provision can be said to be derived from a much wider discourse about the exclusionary nature of public services generally, and of mental health services in particular. In this sense the norms that it contains can be seen as having been communicatively generated in the public sphere.

Furthermore, the fact that the particular aspects of discrimination identified in the Charter are not raised in the consultation exercise itself highlights one of the difficulties in applying the theory of communicative action as a procedural model of deliberation. One of the reasons why other aspects of discrimination are not mentioned is almost certainly that the group consulted were themselves unrepresentative of the wider service user population. Habermas sees participation in communicatively rational discourse as being open to anyone affected by the norms under debate. The problem that anti-discriminatory thinking highlights is the fact that some groups who are indeed affected are unlikely to become participants in the debate, for the very reason that they are discriminated against. It can be argued that communicative rationality is inherently flawed in this respect, that it will always tend to strengthen the claims of those who are most vocal. However, Habermas's spatialized notion of communicative rationality as being generated in the public sphere allows debate to be extended to include a wider range of interests.

In other respects the Charter clearly does reflect the concerns of users expressed in the discussion groups. For instance, one of the clearest discourses that emerges from the consultation exercise is one that centres on the need to be listened to:

- People are not listened to – we need to be listened to.
- Listen to you when you are unwell.
- To be heard feel like have to 'explode'.
- Treated like an individual and adult. I am articulate. Be listened to and listen.
- Nursing staff should be offered counselling training. (Discussion group notes)

These comments find their way directly into the Charter, under the heading *Listening:*

> People need to be listened to, and to be taken seriously. This need is common to service users, carers, volunteers, workers, and agencies. People with problems may need to talk and to be heeded. The listener may need special training.

This statement is a fair reflection of the comments made by service users. However, it also represents an expansion of the principle of listening, emphasizing that it is not only service users who need to be listened to but also those who work with them. By highlighting the humanity of workers the Charter can be seen as serving to 'decolonize' the relationship between workers and users. By stressing the fact that the need to be listened to is a basic human need and not just a feature of the experience of mental illness it is promoting a less instrumentalized view of the mental health service user and of their relationship with those who work in the system.

However, although the statement on listening does highlight one of the main concerns of service users, it fails to capture it fully. In the notes of the discussion groups it is clear that there is also a more specific aspect to this issue, that is the lack of 'professional' listening services available locally:

- Psychiatrists should spend more time with patients.
- We need access to more trained therapists in hospitals and day centres.
- Several people voiced experience of childhood sexual abuse. They felt there was little opportunity to work through these issues. There was no counselling/group therapy or opportunities to talk. They felt staff consider tablets to be the answer – however, the issues never go away.
- Should have chance to see a psychologist.
- 24 hours a day you need access to psychologist/someone to talk to who can understand your problems. (Discussion group notes)

The lack of psychological therapies is an issue that was acknowledged by the statutory mental health agencies at the time the Charter was written. In the Charter, however, no explicit mention is made of this issue, although the statement on *Choice* does make the point that 'there needs to be a range of real alternatives', which can arguably be seen as a very generalized reference to the limited range of therapeutic alternatives to medication available. This example illustrates two things. First, the limited scope of the Charter's influence. It is a purely normative document, whose influence is limited to affecting the manner in which existing services are provided. Secondly, although the Charter is intended to apply throughout the mental health system, it is clearly a document that is aimed primarily at the provider agencies, and it therefore avoids any statement of specifics that might be used to commit the commissioning authorities to particular spending decisions.

The final aspect of the text of the Charter I want to consider is the tone of the language used. A comparison of the notes of the discussion groups with the text of the Charter shows that the Charter presents a picture of the mental health system, as many service users experience it, that is very much toned down. It is particularly illuminating to examine in full the comments of service users that relate to the statement on *Staff*:

- Some concerns were expressed re staff's ignorance about mental health. Service users have felt stereotyped at times.
- Staff don't provide the care and empathy which is needed. They need better psychiatric training which

should be informed by service users and people who have been through the system.

- There should be ongoing support/training/supervision for all staff.
- Nursing staff are stressed out – they are overstretched at times. If there were more and they were better paid, then experienced staff would be able to provide a better quality service. Too much money goes to bureaucracy and 'fat-cat' doctors.
- There was some discussion around the class system and mental health. Different attitudes and services exist for wealthy people with mental health problems – who are thought of as 'eccentric' rather than 'mad'. Private hospitals treat patients with dignity and respect – so this is not an impossible request or task.
- Treated like 'mental health service user'.
- Treated as 'a problem' rather than a *person* with problems.
- Staff attitudes need challenging.
- Some workers don't have good attitude.
- The language and tone used by some staff is bossy, degrading and patronising.
- I feel worse because of disinterested staff, e.g. I wanted to go for a walk. I asked staff, but although they were doing nothing they claimed to be too busy.
- Staff to be more motivated and involved.
- Staff interacting
- Friendship relationships with professionals rather than US/THEM. Staff acting superior.
- Staff need to interact more with patients.
- There is no consistency in messages given out by staff: rules and regulations are governed by an individual's power trip. They should be flexible to suit the service user, not to suit the staff, e.g. some patients are allowed visitors in the lounge – others have to use the dining room. This is often seen as preferential treatment.
- Some of the staff are driven by power.
- Tend to talk at you not to you.
- I would like to feel like an individual – not one of a number.
- The way I was treated when I came in worsened my condition.
- We want RESPECT/INDEPENDENCE.
- Treated as an equal – with respect.
- Treat him with respect.
- I would like to be treated with dignity and respect – not like a dog.
- I would like to be treated like a human being.
- Like human beings.
- We're adults so speak to us respectfully as fellow adult human beings.
- Treated like a human being, an individual.
- Dehumanized.
- 2nd class citizens. (Discussion group notes)

Whilst a few of these comments could be said to be ambivalent, most are critical, and some vehemently so. For instance, lack of respect is a frequent criticism, but in some instances this criticism is made even more strongly, suggesting that staff do not treat service users like human beings. The overall impression from the comments is of a system that is highly instrumentalized, to the point of being dehumanized. In this context it is interesting to consider the Charter's statement on staff:

> People need to be confident that the people who work with them are respected and valued professionals. This means that workers will be aware of the values of the Charter. They will show a respectful attitude towards people using services. They will have appropriate training or qualifications, and real opportunities for ongoing supervision, support and development.

Again, in this statement we see an attempt to 'decolonize', this time by promoting a notion of professionalism that is more humane and reflective, oriented around the principles set out in the Charter. It also emphasizes, again, the humanity of staff as well as of service users. In other words, rather than adopting a confrontational approach, the Charter tries to engender a sense of mutuality between staff and users. The strength of feeling expressed by the service users is captured somewhat more accurately in the preamble to the Charter:

> (…) we recognise that for many people, their experience of mental health services is a negative one. Compulsory treatment under the Mental Health Act, however necessary, can leave people feeling humiliated and degraded. We expect that people will be treated with all due dignity and respect. Anything else is unacceptable.
>
> The Charter is based on what we hold to be basic human rights. We believe that high quality services can only be born out of common decency and mutual respect for one another as human beings.

The key words and concepts that appear in the notes of the discussion groups in relation to staff also appear here – being treated with dignity, respect, like a human being. And again, the idea of mutuality is present. However, the rawness of the service users' comments is lost in translation. This dilution of the strength of service user opinion is recognized as one of the flaws of system-led user involvement.[22] However, I suggest that rather than viewing this as an argument against system-led user involvement, it should instead be seen simply as a limitation of it. The Charter essentially sets out the procedural rights of those who use mental health services as an agenda for incremental normative change.

To conclude this section, I have shown that the text of the Charter does represent the views expressed by service users in the consultation exercise, but in a modified way. The range of norms that it seeks to promote is broader than that represented in the views of the service users. However I contend that this does not mean that the Charter is not underpinned by communicatively generated legitimacy. Those norms that have not acquired their legitimacy directly through the consultation exercise are not invalid, if judged according to Habermas's view of communicatively generated public opinion emerging from the wider public sphere. Indeed if the text of the Charter had been based upon the consultation exercise alone its partiality may have undermined its legitimacy in the local policy field. Essentially, the Charter's legitimacy has been derived from a broader process of argumentation occurring around the periphery of the administrative state. What the consultation exercise has done is to enhance this legitimacy, both in strategic and communicative terms. Its strategic function is clear from the way in which the service user input into the Charter has been emphasized in the forum's literature. However, the fact that the consultation process has been used strategically does not automatically negate the communicative force of the exercise. For the text of the Charter does manage to capture, albeit in slightly modified language, the core concerns of the service users who were consulted. However, what it does is to temper the language in which these concerns are couched in order to produce a document which is likely to be more acceptable to those who work in the system, and thus perhaps more likely to succeed as a 'decolonizing' project. In this particular system context, it is this combination of the strategic and the communicative that gives the Charter its normative force.

Discussion

In this paper I have attempted to demonstrate the value of a Habermasian approach to understanding system-led user involvement initiatives like the Mental Health Charter. I have shown that the thinking underlying the Charter reflects an intuitive grasp of the importance of mutual understanding. There is an awareness that the Charter will carry more authority and will be more likely to succeed in changing the attitudes and behaviour of front-line workers if an effort is made to connect with their own experience. The Charter's emphasis on mutuality and the humanity of both workers and users also suggests that it has a 'decolonizing' role. However, in constructing the text of the Charter the views of service users were subjected to a strategically rational exercise of 'translation' into a document that would be likely to be acceptable to those working in the system. This involved manipulating the views of the service users who participated in the consultation exercise. However, this can be seen as necessary within the constraints of the approach that was adopted. The discussions that were conducted in the consultation days did not reflect a strictly communicatively rational approach. Most importantly, they were not oriented to reaching consensus. The outputs of the discussions were sets of notes reflecting the sometimes diverse views of the service users who took part in them. Constructing the text of the Charter involved a process of thematizing and sifting those views, blending them with norms developed in the public sphere, rejecting those views that did not fit within the overarching normative framework that emerged and using others to reinforce this framework. Importantly, the Charter cannot be understood separately from the wider discursive contexts of system and public sphere from which it emerged. Ultimately, the construction of the text of the Charter must be understood as an exercise in strategic rationality that displays elements of communicative rationality.

The Charter can be thought of as a 'sluice' between the mental health system and the public sphere. Such sluices are valuable in drawing in communicatively generated norms that are derived not only from localized service user experience but also from more generalized perspectives existing in the wider public sphere. In serving this function the Charter differs qualitatively from the kind of charter drawn up by local service providers that sets out the standards of service that users can expect to receive. Such charters can be seen as being concerned primarily with positioning providers in the marketplace of healthcare and, as such, are fundamentally exercises in strategic rationality. However, alongside this type of charter another type of charter now in existence is that developed as a campaigning tool, promoting at a local, national or international level the rights and interests of certain sections of the population. Examples in the health sector include the UK Lung Cancer Patients' Charter (http://www.roycastle.org/campaign/Patients_Charter.pdf) and the international Patients' Charter for Tuberculosis Care (http://www.stoptb.org/globalplan/assets/documents/IP_OMS_Charte_GB_Epreuve.pdf). This type of charter is developed by external agencies wanting to exert pressure on policy makers, as well as on commissioning and providing organizations, to change their policy and practice. Whilst not in themselves necessarily the product of communicatively rational deliberation, such documents can be seen as contributing to a wider communicatively rational field of discourse that influences the development of policy. The Mental Health Charter discussed here is more akin to this kind of discursive, progressive charter than to the consumerist provider-led charters resulting from the embedding of 'charterism' within the NHS.

More than a decade after the publication of the Charter, the policy context in which it was constructed has changed considerably. User involvement has become a requirement at all levels of policy-making and service delivery. Various mechanisms exist to ensure that such involvement is meaningful, with organizations such as the NHS Centre for Involvement, Shaping Our Lives and National Voices engaged in work towards 'mainstreaming' user involvement. A considerable body of evidence is emerging on the use of diverse models of involvement and engagement, including those derived from ideas of deliberative democracy. Indeed, it may be that if the Charter were to be constructed today it would be constructed in a way that was more communicatively rational, using more sophisticated deliberative techniques. User involvement is no longer likely to be limited to consultation in which the views of those consulted may be used, albeit with the best of intentions, in support of pre-defined agendas. Instead, more sophisticated understandings of different forms and levels of involvement are becoming incorporated into the knowledge and practice of many health and social care organizations, particularly in the field of mental health. These developments are valuable in providing more 'sluices' into the administrative state from the public sphere, enabling service users, both collectively and individually, to influence policy, and making services more directly accountable to the people who use them.

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None.

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