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Original Research

A qualitative study exploring mental health professionals' perspectives, opinions, and attitudes on the state of service users' rights

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Abstract

Background: The rights of mental health service users are a subject of profound debate. In this article, we aim to examine mental health professionals' perspectives, opinions, and attitudes on the state of service users' rights.

Methods: We conducted a thematic analysis of eleven focus groups involving mental health professionals.

Results: Through this process, we identified two main meta-themes that shed light on the challenges faced by mental health service users: *'Transforming the therapeutic relationship'* and *'Societal determinants of service users' rights'*. Within the former meta-theme, we identified the following themes: '*Diversifying mental health knowledge*', '*Risk-protection tensions*', and *'Being (ir)responsible'*. Within the latter meta-theme we identified *'Determinants inside the clinics'* and *'Determinants outside the clinics.'*

Conclusions: Reflecting on these themes could potentially encourage new strategies to support professionals in overcoming the subjective barriers that prevent their adherence to rights-based mental health care models.

Keywords: Coercion; convention on the rights of persons with disabilities; justifying beliefs; rights-based mental health care

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Introduction

Following the enactment of the Americans with Disabilities Act (National Council on Disability 1990) and the Convention on the Rights of Persons with Disabilities (CRPD; United Nations 2006), the acknowledgement of the rights of individuals diagnosed with mental disorders has evolved into a subject of widespread public debate. The CRPD focuses on essential principles such as eradicating coercion and paternalism. The elimination of all forms of coercion is explicitly stated in articles such as 14 (liberty and security of the person) and 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), while supporting individual autonomy is a recurring theme throughout the convention, clearly emphasised in articles 12 (equal recognition before the law), 19 (living independently and being included in the community), 21 (freedom of expression and opinion, and access to information), and 25 (health).

Building upon this international framework, endeavours to implement rights-based mental health projects have proliferated (Porsdam Mann *et al.* 2016). Previously unquestioned coercive practices are now being scrutinised, leading to a surge in studies focused on identifying effective methods to reduce or eliminate them (Scanlan 2010; Stewart *et al.* 2010; Goulet *et al.* 2017; Oostermeijer *et al.* 2021). Similarly, intervention models that advocate for a paradigm shift from merely addressing symptoms to actively supporting the overall recovery journey of service users, with a strong emphasis on their participation, have transitioned from being on the fringes to becoming mainstream. Notably, approaches like Recovery, which emphasise personalised care tailored to help individuals achieve their fullest potential by fostering resilience and community integration, have gained widespread acceptance and recognition (Pincus *et al.* 2017). A prime example of the influence of this advancements is the World Health Organization's (2012, 2021) proactive response with the publication of a series of guidance and technical packages on the promotion of person-centred and rights-based approaches within community mental health services.

However, despite the generalised acceptance of the so called 'rights framework' by most mental health services administrations around the world, this has happened with certain reservations. Numerous professional associations (e.g. Spanish Society of Psychiatry 2020) and legislators (e.g. Alexandrov and Schuck 2021) have raised questions concerning the boundaries of the CRPD, particularly in relation to its Article 12, which addresses

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equal recognition before the law, and its implications for professional competencies. One of the primary arguments is that a stringent interpretation of the CRPD could hinder professionals from implementing involuntary interventions aimed at saving the lives of individuals who pose a risk to themselves or others due to their psychopathology (Freeman *et al.* 2015; Appelbaum 2019; Spanish Society of Psychiatry 2020; Alexandrov and Schuck 2021). From a range of critical perspectives, including those of clinicians, academics, and advocacy groups, it is argued that merely allowing these measures encourages their extensive application. This is evidenced by the fact that professionals who more frequently utilise such measures tend to provide more justifications for their use (Molewijk *et al.* 2017). In addition, these voices contend that relying solely on an ethical perspective, as previously upheld by major psychiatric organizations, falls short in providing the necessary accountability for accomplishing the elimination of coercion in mental health care (Lewis and Callard 2017). Furthermore, a commonly raised concern is that the principles of seemingly rights-based approaches like Recovery have been distorted. This distortion is observed in numerous organizations through the use of strength-based concepts for outreach while maintaining deficit-based practices internally (Howell 2012; Rose 2014; Thomas 2016). Alarmingly, certain types of coercion, such as compulsory community treatment, have been even rationalised as a means to facilitate the path to recovery (Eiroa-Orosa and Rowe 2017).

Beyond the ongoing public debates, everyday professional experiences also highlight a pervasive symbolic validation of coercive and paternalistic practices (Mckeown *et al.* 2019). Concurrently, the practical implementation of rights-based approaches remains elusive for many professionals who genuinely aspire to work in more supportive ways. To address these barriers effectively, it is essential to gain deeper insights into mental health professionals' perspectives on their service users' rights. However, the current body of qualitative research on this matter remains relatively limited. Some studies have touched upon mental health professionals' views on coercion, particularly justifying informal coercion as an effective means to reduce the need for stronger, more forceful measures (Valenti *et al.* 2015; García-Cabeza *et al.* 2017; Pelto-Piri *et al.* 2019). Furthermore, some discussions delve into the obstacles that hinder the implementation of rights-based approaches and the full citizenship of individuals with psychosocial disabilities. These barriers encompass concerns about the mental health system's capacity to address issues that extend beyond its boundaries (Ponce *et al.* 2016). To address these gaps in the literature, we aimed to examine the views of mental health professionals in a context where traditional paternalistic perspectives coexist with models that emphasise the rights of service users.

Method

Design

Data collection involved conducting eleven focus groups with a broad spectrum of mental health professionals working in various clinical and social settings (ranging from community-based to hospital settings) in Catalonia (Spain). The first author, who is also leading a broader project aimed at transforming mental health care systems toward rights-based care (Eiroa-Orosa and Rowe 2017), facilitated all focus groups.

Participants

A total of 65 professionals from diverse backgrounds, encompassing nursing (14), occupational therapy (3), psychiatry (10), psychology (14), social work (15), social education (7), and other related professions (2), were recruited through their respective line managers. There were 33 men and 42 women, and the average age was 42.8 years.

Both authors are committed with right-based models of mental health. To acknowledge professionals' viewpoints on this topic, an open and empathetic listening attitude was adopted to understand the participants' views and perspectives.

Procedure

Each focus group comprised four to ten individuals. The duration of each session ranged between 60 and 120 minutes. To foster meaningful dialogue among professionals, they were asked to complete the preliminary 40-item version of the Beliefs and Attitudes towards Mental Health Service Users' Rights Scale (Eiroa-Orosa and Limiñana-Bravo 2019). The use of this questionnaire aimed to elicit practitioners' perspectives on various aspects, including the justification or criticism of the mental health care system, attitudes toward coercion, preferences for paternalistic approaches versus empowerment, and levels of tolerance or discrimination towards individuals diagnosed with mental health disorders. Subsequently, participants engaged in discussions. The main prompt was to inquire about their opinion on the state of the rights of service users, with investigators facilitating and stimulating discussion as needed. For instance, and depending on the group dynamics, investigators deepened on specific rights (e.g., the equal recognition before law) or specific practices (e.g., informal coercion or alternatives) but standardised questions were not used. All sessions were recorded for further analysis.

Data analysis

Focus group recordings were transcribed verbatim, and a subsequent analysis was conducted. Given the exploratory nature of the study, we opted for Braun and Clarke's (2006) thematic analysis (TA). This approach enabled us to systematically identify, analyse, and establish patterns of meaning. TA offers the flexibility to incorporate categories aligned with a rights-based mental health theoretical framework, helping us seek narratives on the status of service users' rights. Data analysis commenced once all data collection had concluded. For analysis purposes, the ATLAS.ti software was utilised.

TA involves distinct stages to ensure comprehensive understanding of the data. The initial stage comprises deep familiarization, achieved through multiple readings of the transcripts. Afterwards, line-by-line coding starts, encompassing the identification of all relevant elements. In the following stage, focused coding takes place, where codes begin to be grouped into potential themes. This stage involves an interpretive process that combines descriptive and latent meanings of the data. As the analysis progresses, themes are developed, leading to the identification of a smaller set of core themes. In the subsequent stage, these themes are refined, named, and their content thoroughly described. Throughout this process, the original data are continually revisited and reorganised. Finally, the findings are meticulously written and polished to articulate the patterns of meaning from the data. Given that thematic saturation was attained through the information obtained from the eleven focus groups, there was no need for further data collection.

A preliminary analysis was carried out by the second author, who proposed an initial organization of the codes into subthemes, themes, and meta-themes. After discussing these analytical insights with the first author, both engaged in an iterative process of collective analysis to validate and corroborate data interpretations. For space reasons, only shortened extracts are presented in the theme descriptions. Illustrative extracts for each subtheme and frequencies may be consulted in Table 1.

Results

Building upon the notion that professionals' beliefs and attitudes toward service users' rights encompass multiple dimensions (Eiroa-Orosa and Limiñana-Bravo 2019), we have developed two overarching meta-themes that organise the diverse mental health professionals' narratives found. The first meta-theme, *Transforming the therapeutic relationship,* includes various statements where professionals acknowledge and negotiate their role in the therapeutic relationship if they consider service users as subjects of rights. The second meta-theme, *Societal Determinants of Service Users' Rights,* involves various narratives rooted in the contextual aspects of mental health practice, including cultural and structural tensions and impediments that affect service users' rights. Within each meta-theme, themes are further divided into different sub-themes.

Transforming the therapeutic relationship

Introducing rights in clinical practice transforms the relationship between mental health professionals and their service users. Specially as it means that they can decide about their own lives and treatment. Four main themes illustrate the principal challenges and resistances within professionals' narratives.

Diversifying mental health knowledge

This theme encompasses arguments where professionals discuss about who holds the knowledge within the therapeutic relationship. Three main narratives challenge and resist the idea that service users may know what they need in different situations.

'It's difficult to take decisions when you have a lack of knowledge and training. (. . .) There is a point that requires trust in professionals and in their criteria and knowledge.' (Group 6)

Professionals' technical expertise

Emphasising technical knowledge is a way to justify professionals' decisions on service user's lives and treatment.

Service users' knowledges

Service users' decision-making capacity is conditioned by whether they are perceived by professionals as knowledgeable subjects. Technical examples are frequently employed to support the justification of unilateral professionals' decisions.

Professionals' training

Professionals tend to acknowledge the need for training on various aspects of their clinical practice. For example, they express concerns about not knowing how to address service users' demands, admit being unfamiliar with treatment alternatives, or recognise their own professional biases.

Risk-protection tensions

This theme collects narratives where professionals discuss about who needs to be protected and which are the risks in the mental health healthcare context.

'I think that involuntary hospital admissions should be respected. I remember some specific cases . . . For example, a patient who had climbed a high voltage tower and was very psychotic. He almost died. These things happen.' (Group 3)

Vulnerable service users

In these excerpts professionals often invoke service users' vulnerability and the necessity of their protection to justify certain practices that infringe upon fundamental rights. We identified instances of infantilization and use of extreme situations where they attempt to emphasise service users' alleged incapacity to exercise their rights.

Protecting professional status

Many participants recognise that they reject certain service users' decisions because they challenge professionals' status.

Being (ir)responsible

This theme is related to the ethical value of responsibility. The theme can be best comprehended by examining its two subthemes.

'Integrating the other's opinion means accepting that the other can also be wrong, it is their decision in the end, not yours.' (Group 4)

Professional accountability

In the therapeutic relationship, professionals often perceive themselves as responsible for service users' decisions. Beyond their medical-legal accountability, professionals feel some pressure to decide on matters affecting service users' lives.

Service users (ir)responsibility

Simultaneously, professionals recognise that service users are also competent to have a voice in their own treatment. These service users' views may be a font of reflection for professionals. On other occasions, they may resist service users' opinions by distinguishing between 'responsible' and 'incompetent' individuals.

Societal determinants of service users' rights

This meta-theme encompasses quotations where professionals discuss the structural determinants of service users' rights. Participants often depict situations that exceed their individual capacity for transformation. We differentiate between narratives that pertain to clinical institutions and those that reference the broader social context.

Determinants inside the clinics

Many participants emphasised that the organizational structure of mental health services is the primary determinant of service users' rights. They state that without adequate training, time, and material resources, implementing change becomes an insurmountable challenge.

'We don't have enough resources to be able to offer more spaces based on the word, and therefore if a psychiatrist takes four hundred patients, that's a little bit what I was asking about . . . about mechanical restraint, right? Sometimes if there's no staff it's the only way.' (Group 6)

Table 1. Meta-themes, themes and subthemes found through thematic analysis, their frequencies and illustrative extracts

Meta-themes	Themes	Sub-themes	Illustrative extracts
Transforming the therapeutic relationship (636)	Diversifying mental health knowledge (223)	Professionals' technical expertise (58)	"Sometimes you see decompensations in early stages of the illness, and you know what is going to happen. It's not easy to take a decision" (Group 3).
		Service users' knowledges (32)	"To make a question you have to know something about it. It's difficult to take decisions when you have a lack of knowledge and training. How am I going to ask the doctor, for example, what prosthesis is going to put on me? So, "Why don't you use another prosthesis? Why do you choose this treatment?" I would have to do a whole training to be able to ask myself what type of prosthesis is the most appropriate. It would be a ridiculous situation. There is a point that requires trust in professionals and in their criteria and knowledge. So, it is not appropriate to ask service users whether they want to be restrained or not. (Group 6)
		Professionals' training (133)	"There is also a lack of training among mental health professionals because their training is very poor, right? In that sense the response they [professionals] offer is very poor in many situations" (Group 9). "Interviewer: Do you know any advance directives protocols? P3: No P2: No P4: No" (Group 7).
	Risk-protection tension (164)	Vulnerable service users (81)	"Because it's also sad, isn't it? Seeing that they want to take care of children, and take care of them and have them, and no . . . And they cannot be there for them because that is it, relapses one after another, and they do not have the awareness that at that moment something is happening to them. How can they . . . of course, if they can't take care of themselves, how can they take care of other 'smaller' people?" (Group 7) "I think that involuntary hospital admissions should be respected. I remember some specific cases . . . For example, a patient who had climbed a high voltage tower and was very psychotic. He almost died. These things happen. If you give a person the option to decide, things like this happen. Sometimes. For this reason, we need the tools to protect the person." (Group 3)
		Protecting professional status (83)	P7: I think that the main difficulty is in roles. P6: Give up the power. P1: It will be difficult. P5: The fact that we will have to recognise that we are in the same position that the diagnosed person. The fact that I must listen what they say" (Group 1) Now everyone knows more than anyone and there is a massive dissemination of information in minds that perhaps are not capable of handling that information, so doctors and psychologists are increasingly losing professional status. I do not talk about pathological deification, but our experience is undervalued. (Group 10)
	Being (ir)responsible (249)	Professionals accountability (137)	"Integrating the other's opinion means accepting that the other can also be wrong, it is their decision in the end, not yours. You are not wrong, they are wrong" (Group 4). "I remember when I worked at the guardianship foundation. I remember that, well, as a matter of sympathy we put two or three people in a flat, but of course, it was a bit like 'we are doing something illegal.'" (Group 4)
		Service users (ir) responsibility (112)	"In everyday life people are not aware that they have rights. Don't you think so? So, any question about what they want to do with their life they say: "what do you think about it?" or "I will talk with my mother to know her opinion" or "I'm going to talk to my psychiatrist to see what she thinks." (Group 1) "There are people who can mature and people who are forty and still ask you: 'What do I have to do? I don't know how to make a sandwich. Feed me. Give me a drink'. They arrive to the service where you are working, and they don't know anything. So, you have to accompany them, you have to show the person how to live and how to live together and do things on their own." (Group 8) "I can imagine certain patients doing this role [peer support] and it would be great and there would be a lot of people who could benefit from their participation. But I can also imagine others who would initially give themselves fully for it, but then possibly it would affect them in a way . . . I don't know . . . if completely positive, or could . . . and that, at some point even, they would be at risk of decompensation. I mean, it is a good idea, but it has to be done carefully. (Group 5)

(*Continued*)

Table 1. (*Continued*)

Meta-themes	Themes	Sub-themes	Illustrative extracts
Societal determinants of service users' rights (570)	Determinants inside the clinics (353)	Historical clinical prejudices (175)	"Humanity is blurred, the values of that person, the values of humanity are in a therapeutic context, in a mental health center, let's say, they disappear. The picture is different, I am here, and you are there, but it is not a human relationship. (Group 4) "Psychiatrists, well, I think there is still a "hard core". I would call them the hard core of biological psychiatry, which has not changed, almost nothing. In other words, it is still the doctor who directs the treatment, the one who prescribes, the one who says whether hospitalization is appropriate or not." (Group 10) "In other words, but simply because of the . . . because of the construction of what a personality disorder is, how this diagnosis is constructed . . . I mean, it is already happening. Let's say . . . I mean, you interpret those behaviors already within that diagnosis? Don't you?" (Group 10) "I continue to see many people who, from paternalism, allow themselves everything. And I'm talking about specific professionals, right? Who prescribe lithium 'And you take lithium because I, your psychiatrist, say so' you know?" (Group 3)
		Unsuitable working conditions (134)	"In other words, even the people who have this different way of working very, very, very much in their heads, the way practices are today it is complicated that in a 15-minute visit you can do the whole process of connecting with the patient, and to explain very well, because the consultation just ends." (Group 3) "To begin with, because we don't have, as you said, time. We don't have enough resources to be able to offer more spaces based on the word, and therefore if a psychiatrist takes four hundred patients, that's a little bit what I was asking about . . . about mechanical restraint, right? Sometimes if there's no staff it's the only way. Well, surely, if there isn't a nurse, or two nurses, and a person who stays and there are other people in the ward, then . . . Well, I think we should try other things but surely, without resources, the answer is always more deficient, isn't it? And also, with that, right? Because we probably often use drugs because there are no . . . there are no other resources to offer." (Group 6)
		Excessive bureaucratic tasks (44)	"Bureaucracy, we prioritise that part and leave care away" (Group 9). "There is a lot more bureaucracy to put everyone in their place. So, the referral from one place to another will depend on all this, on all these administrative issues, which are also mixed with all these statistical matters. That is, the National Health Service asks you for this. At the time of reporting how you reflect it, then come the tricks that we have to do to make everything fit (laughter). This is another one. Let's not fool ourselves, right?" (Group 9)
	Determinants outside the clinics (217)	Cultural understandings of mental health (113)	"We are working in institutions with an economistic discourse where we have to respond almost more, not so much about what we do with the patient at a qualitative level, but quantitative, okay? And it collides with the issue of rights for both the professional and the patient. In other words, today with all this discourse on rights, on another vein, as a counterpart, there is another discourse where the patient, the user, has to be relieved, has to be productive, has to, has to, has to . . . " (Group 6) "But yes, because I think there is a stigma because I had since I finished my degree . . . I'm a nurse and I was clear that I wanted psychiatry, and my classmates told me, but why are you going to end up there if that does it look like a jail? That is not going to gratify you in any way, or anything." (Group 7)
		Legal frameworks and economical functioning (104)	"What happens? That the system prioritises the desire for profit, even if they are non-profit organizations. They prioritise economic prosperity and programs that give more money" (Group 1). "Or about contributory pensions, you do not have the right to leave the pension for a while to start working and try to move forward with your life. You are forced to accept the pension forever or lose it and . . . and be left with nothing, right?" (Group 1)

Historical clinical prejudices

Participants express that certain 'prejudiced' ideas about mental health problems significantly influence their clinical practice. Prominent examples of such ideas include depersonalization, biologicism, psychiatric categorization, and paternalism.

Unsuitable working conditions

Narratives discussing the reliance of mental health settings on material resources are also commonly found. For instance, professionals discuss the lack of time available to attend to service users, inadequate spaces, and understaffing as significant challenges.

Excessive bureaucratic tasks

Participants emphasised the bureaucratic side of their jobs. This indicates a growing technification of procedures that prioritise the needs of provider organizations.

Determinants outside the clinics

This theme includes all the expressions where participants stress the existence of shared ideas and social structures that determine service users' rights.

'I think there is stigma because I had since I finished my degree . . . I'm a nurse and I was clear that I wanted psychiatry, and my classmates told me, but why are you going to end up there if that does it look like a jail?' (Group 7)

Cultural understandings of mental health

Participants assert that social beliefs about mental health significantly influence professional actions within the clinical context. This sub-theme primarily highlights references to stigma and the invisibility of suffering. Additionally, neoliberal conceptions of the individual, which emphasise self-sufficiency and productivity, are mentioned, reinforcing health prejudices within clinical relationships.

Legal frameworks and economical functioning

Some participants reveal that legislation, political decisions, and economic interests directly impact the access of individuals with a mental health diagnosis to various resources. Recurring concerns involve the pension system and legal disability procedures, as well as the profit interests of guardianship foundations.

Discussion

We conducted a thematic analysis of focus groups carried out with mental health professionals, exploring their perspectives, opinions, and attitudes on the state of service user rights. The inclusion of a broad range of professions and settings contributes to the study's richness, providing a diverse spectrum of pragmatic, theoretical, and ideological perspectives on mental health. Our findings reveal that although mental health professionals recognise the importance of service users' rights and the need for user-centred care, significant challenges remain in translating these values into practice. These challenges include entrenched paternalistic attitudes, limited resources, and systemic constraints within mental health services. To address these deficits, services must prioritise comprehensive training that emphasises recovery-oriented practices, increase resource allocation to support service user autonomy, and implement policies that facilitate the integration of recovery principles into everyday clinical practices.

Two meta-themes were developed and account for the transformations of the therapeutic relationship and different societal determinants. This twofold analysis aligns with the psychometric results obtained from the Beliefs and Attitudes towards Mental Health Service Users' Rights Scale (Eiroa-Orosa and Limiñana-Bravo 2019) in which system justifications explain most of the variance.

In relation to the transformation of the therapeutic relationship, we identified various reluctances to fully consider service users as subjects of rights. While professionals acknowledge the importance of addressing service users' demands and proposals, they simultaneously assert the primacy of their technical knowledge. Our data suggest that mental health professionals tend to overestimate service users' need for protection and their own level of responsibility. These three themes are juxtaposed against the other, wherein professionals are perceived as possessing the capacity to know, protect, and be responsible, while some individuals diagnosed with mental health conditions are depicted as lacking agency and needing assistance. Consequently, in these clinical relationships, professionals prioritise these three values at the expense of the service users' right to make decisions.

Social identity theories (Tajfel and Turner 1979) can be used to interpret these results, as they are frequently used to understand the development of distinct professional identities (e.g. Coleman 2019). Changing professional practices may pose a challenge to maintaining the distinction between the social identities of professionals and service users within the clinical relationship. Even if some of the practices prove to be ineffective or even iatrogenic, they are perceived as an integral part of the professional praxis that transcends the boundaries of specific techniques; they are inherent to the professional identity and ethos of these practitioners (Feldmann 2014). The obstacles to embracing a right-based model stem from the factors that differentiate the professional position. In a sense, eliminating certain coercive practices could imply a loss of social status (Breakwell 1986) and a challenge to their technical expertise. Our study highlights that examining positional dynamics within therapeutic relationships may illuminate the understanding of resistances to implementing a rights-based mental health care model.

Furthermore, the intergroup dynamics within clinical relationships should be viewed not merely as distinctions but as hierarchies based on the moral and epistemic privilege of professionals. This group is perceived to possess more positive characteristics compared to service users, which legitimises their practices and decisions (Tajfel and Turner 1979). We must also consider that the social identity of mental health service users is stigmatised both within clinical settings and society at large (Corrigan 2004; Pellegrini 2014). Individuals are often viewed through the lens of negative characteristics associated with the stigmatising labels of mental health diagnoses, leading to the attribution of 'spoiled' identities (Goffman 1963). Consequently, our findings suggest that maintaining and exacerbating the distinction between professionals, who are perceived as capable, and service users, who are deemed incapable, perpetuates these social hierarchies and reinforces the stigmatised identities of the latter. This further hinders the reversal of the social meaning attributed to them.

Upon further examination, it becomes evident that knowledge, protection, and responsibility are highly esteemed values in liberal democracies. In line with this, discursive psychology has illustrated that the invocation of liberal values can serve illiberal goals, such as perpetuating racist discourses (e.g., Augoustinos and Every 2007; Wetherell and Potter 1992). Values can be employed to perpetuate exclusion and discrimination under the guise of social acceptance. Our findings suggest that arguments supporting the preservation of the professional role reproduce this discursive mechanism when they oppose service users' rights to knowledge, protection, and responsibility. In doing so, they may inadvertently contribute to maintaining unjust power dynamics and perpetuating practices that undermine the rights and autonomy of mental health service users.

In contrast, our results also reveal signs of awareness within clinical practitioners. There are instances of reflection where professionals acknowledge their lack of proper training to change their practices or when they claim to have overcome historical prejudices. Similar reasoning is found in related studies (Ponce *et al.* 2016). Acknowledging the need for professionals to enhance their training and knowledge demonstrates a willingness to learn and change the current status quo toward clinical rights-based interventions. However, the literature on the introduction of recovery-based approaches commonly accepts that beliefs and attitudes are easier to change than practices (Eiroa-Orosa and García-Mieres 2019). Our results indicate that professionals are receptive to new models, but they require practical tools to intervene and (re)define their position in the clinical relationship.

The second set of narratives addresses cultural and structural barriers, both within and outside clinical institutions. Within the Catalan mental healthcare system, various prejudiced dynamics hinder the perception of service users as subjects of rights (Eiroa-Orosa and Rowe 2017). Paternalist conceptions perpetuate the notion that professionals must rescue or cure the 'defenseless' and 'incapable' service users, impeding the acknowledgement of their demands and opinions.

Our findings suggest several intervention directions. First, there is a pressing need for specific rights-based training, with explicit support from managerial roles, encompassing diverse, nuanced, and reflective understandings of psychiatric diagnoses and categories. Secondly, increasing the ratio of professionals and streamlining administrative processes would enable necessary structural transformations for change. Although these changes present significant challenges for public administrations, genuine transformation can only be achieved through the coordination of different stakeholders at various levels.

At the societal level, professionals highlight cultural and legal barriers that impede their full adherence to the rights of service users as mandated by new regulations. Effecting change in clinical practices requires altering the broader context, as they are influenced by cultural imperatives and legal frameworks that dictate permissible actions. Despite an international commitment to the social model of disability, regulations concerning social assistance for people with psychosocial disabilities remain entrenched in paternalism, rooted in traditional, biomedically influenced explanations of mental disorders (Vanhala 2006; Wardana and Dewi 2017). Even though evidence contradicts the effectiveness of biological explanations for reducing stigma or increasing clinician empathy towards psychological distress and addictions (Read *et al.* 2006; Lebowitz and Ahn 2014), 'brain disease' models remain mainstream in psychiatric academia and practice and are used as outreach tools by its proponents increasing its social penetrance (Schomerus *et al.* 2012). The perception of mental health in both clinical and general societal contexts remains burdened with taboos, despite purported efforts to normalise experiences of mental distress (Read *et al.* 2006; Schomerus *et al.* 2012; Lebowitz and Ahn 2014).

This study has some limitations stemming primarily from the use of focus groups in various care settings within a single cultural context. Each focus group developed uniquely, and topics covered varied, largely influenced by the characteristics of each healthcare context. Nevertheless, theoretical saturation was achieved in all themes, compensating for this limitation. Additionally, the specific sociocultural context where the focus groups were conducted renders the findings specific to a particular place and time. The tension between the need for homogeneity to capture narratives in a given context versus the need for representativeness in different healthcare contexts could be analysed (Roller and Lavrakas 2015). However, as mentioned earlier, this study is tied to a transformation project for a specific healthcare system (Eiroa-Orosa and Rowe 2017), and the findings should be understood from a pragmatic perspective. Consequently, the conclusions cannot be directly extrapolated to other contexts, but they serve as an illustration of professional narratives that justify certain practices and offer inspiration for strategies to transform them.

In conclusion, this study aimed to explore the perspectives, opinions, and attitudes of mental health professionals on the state of service user rights to gain a better understanding of the existing limitations within care systems. Focusing on these limitations not only deepens our comprehension of the challenges in implementing a rights-based mental health care system, but also sheds light on the potential courses of action that could bring about substantial change. Listening to professionals as they reflect on their practices is crucial for a comprehensive understanding of how mental health services operate, their potentialities, and their limitations. Our study underscores the value of collaborating with professionals to propose transformative public policies that can bring about significant changes in mental health services, ultimately committed to the rights of service users.

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Competing interests. Both authors share a strong commitment to fighting stigma in mental health and advocating for care systems that prioritize the rights and citizenship of service users. This ideology is evident throughout their research, influencing both their choice of topics and approach to data analysis. In this regard, they adopt a critical axiological stance that advocates for the establishment of research spaces dedicated to driving social transformation.

Ethical standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. Informed consent was obtained from all participants. Ethical approval for the study was granted by the University of Barcelona institutional review board (IRB00003039).

References

Alexandrov NV, Schuck N (2021). Coercive interventions under the new Dutch mental health law: towards a CRPD-compliant law? *International Journal of Law and Psychiatry* **76**, 101685.

Appelbaum PS (2019). Saving the UN Convention on the rights of persons with disabilities – from itself. *World Psychiatry* **18**, 1–2.

Augoustinos M, Every D (2007). The language of 'race' and prejudice. *Journal of Language and Social Psychology* **26**, 123–141.

Braun V, Clarke V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**, 77–101.

Breakwell GM (1986). *Coping with Threatened Identities*. Psychology Press: Hove, UK.

Coleman P (2019). Cultural differences in general and psychiatric nurses: a critical analysis using social identity theory. *Aporia* **10**, 17–27.

Corrigan P (2004). How stigma interferes with mental health care. *American Psychologist* **59**, 614–625.

Eiroa-Orosa FJ, García-Mieres H (2019). A systematic review and meta-analysis of recovery educational interventions for mental health professionals. *Administration and Policy in Mental Health and Mental Health Services Research* **46**, 724–752.

Eiroa-Orosa FJ, Limiñana-Bravo L (2019). An instrument to measure mental health professionals' beliefs and attitudes towards service users' rights. *International Journal of Environmental Research and Public Health* **16**, 244.

Eiroa-Orosa FJ, Rowe M (2017). Taking the concept of citizenship in mental health across countries. Reflections on transferring principles and practice to different sociocultural contexts. *Frontiers in Psychology* **8**. doi:10.3389/fpsyg.2017.01020.

Feldmann TB (2014). Understanding the dynamics of change and the impact on psychiatric education. *Academic Psychiatry* **38**, 672–679.

Freeman MC, Kolappa K, de Almeida JMC, Kleinman A, Makhashvili N, Phakathi S, Saraceno B, Thornicroft G (2015). Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *The Lancet Psychiatry* **2**, 844–850.

García-Cabeza I, Valenti E, Calcedo A (2017). Perception and use of informal coercion in outpatient treatment: a focus group study with mental health professionals of Latin culture. *Salud Mental* **40**, 63–69.

Goffman E (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall: Englewood Cliffs, NJ.

Goulet M-H, Larue C, Dumais A (2017). Evaluation of seclusion and restraint reduction programs in mental health: a systematic review. *Aggression and Violent Behavior* **31**, 413–424.

Howell A (2012). Introduction: the politics of resilience and recovery in mental health care. *Studies in Social Justice* **6**, 1–7.

Lebowitz MS, Ahn W (2014). Effects of biological explanations for mental disorders on clinicians' empathy. *Proceedings of The National Academy of Sciences of The United States of America* **111**, 17786–17790.

Lewis O, Callard F (2017). The World Psychiatric Association's 'Bill of Rights': a curious contribution to human rights. *International Journal of Mental Health* **46**, 157–167.

Mckeown M, Scholes A, Jones F, Aindow W (2019). Coercive practices in mental health services: Stories of recalcitrance, resistance, and legitimation. In *Madness, Violence, and Power*, pp. 263–285. University of Toronto Press: Toronto.

Molewijk B, Kok A, Husum T, Pedersen R, Aasland O (2017). Staff's normative attitudes towards coercion: the role of moral doubt and professional context - a cross-sectional survey study. *BMC Medical Ethics* **18**, 1–14.

National Council on Disability. (1990). *Americans with Disabilities Act*. United States Code: Washington, DC.

Oostermeijer S, Brasier C, Harvey C, Hamilton B, Roper C, Martel A, Fletcher J, Brophy L (2021). Design features that reduce the use of seclusion and restraint in mental health facilities: a rapid systematic review. *BMJ Open* **11**, 1–17.

Pellegrini C (2014). Mental illness stigma in health care settings a barrier to care. *Canadian Medical Association Journal* **186**, E17–E17.

Pelto-Piri V, Kjellin L, Hylén U, Valenti E, Priebe S (2019). Different forms of informal coercion in psychiatry: a qualitative study. *BMC Research Notes* **12**, 10–13.

Pincus HA, Spaeth-Rublee B, Ramanuj PP (2017). Bringing recovery and consumers' views into the mainstream of mental health quality measurement. *Psychiatric Services* **68**, 1182–1184.

Ponce AN, Clayton A, Gambino M, Rowe M (2016). Social and clinical dimensions of citizenship from the mental health-care provider perspective. *Psychiatric Rehabilitation Journal* **39**, 161–166.

Porsdam Mann S, Bradley VJ, Sahakian BJ (2016). Human rights-based approaches to mental health: a review of programs. *Health and Human Rights Journal* **16**, 263–276.

Read J, Haslam N, Sayce L, Davies E (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica* **114**, 303–318.

Roller MR, Lavrakas PJ (2015). *Applied qualitative research design: A total quality framework approach*. The Guilford Press: New York, NY, US.

Rose D (2014). The mainstreaming of recovery. *Journal of Mental Health* **23**, 217–218.

Scanlan JN (2010). Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far a review of the literature. *International Journal of Social Psychiatry* **56**, 412–423.

Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, Carta MG, Angermeyer MC (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica* **125**, 440–452.

Spanish Society of Psychiatry (2020). Stance of the Spanish Society of Psychiatry regarding the United Nations Convention on the rights of persons with disabilities. *Revista de Psiquiatría y Salud Mental (English Edition)* **13**, 177–179.

Stewart D, Van der Merwe M, Bowers L, Simpson A, Jones J (2010). A review of interventions to reduce mechanical restraint and seclusion among adult psychiatric inpatients. *Issues in Mental Health Nursing* **31**, 413–424.

Tajfel H, Turner J (1979). An integrative theory of intergroup conflict (eds. Worche S and Agustin WG), pp. 33–45. Brooks/Cole: Baltimore, MD.

Thomas P (2016). Psycho politics, neoliberal governmentality and austerity. *Self & Society* **44**, 382–393.

United Nations. (2006). Convention on the rights of persons with disabilities. *Treaty Series* **2515**, 3.

Valenti E, Banks C, Calcedo-Barba A, Bensimon CM, Hoffmann KM, Pelto-Piri V, Jurin T, Mendoza OM, Mundt AP, Rugkåsa J, Tubini J, Priebe S (2015). Informal coercion in psychiatry: a focus group study of attitudes and experiences of mental health professionals in ten countries. *Social Psychiatry and Psychiatric Epidemiology* **50**, 1297–1308.

Vanhala L (2006). Fighting discrimination through litigation in the UK: the social model of disability and the EU anti-discrimination directive. *Disability and Society* **21**, 551–565.

Wardana A, Dewi NPYP (2017). Moving away from paternalism: the new law on disability in Indonesia. *Asia-Pacific Journal on Human Rights and the Law* **18**, 172–195.

Wetherell M, Potter J (1992). *Mapping the language of racism*. Columbia University Press: New York, NY.

World Health Organization (2012). *QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities*. World Health Organization: Geneva.

World Health Organization (2021). *Guidance on Community Mental Health Services: promoting person-centred and rights-based approaches*. World Health Organization: Geneva.